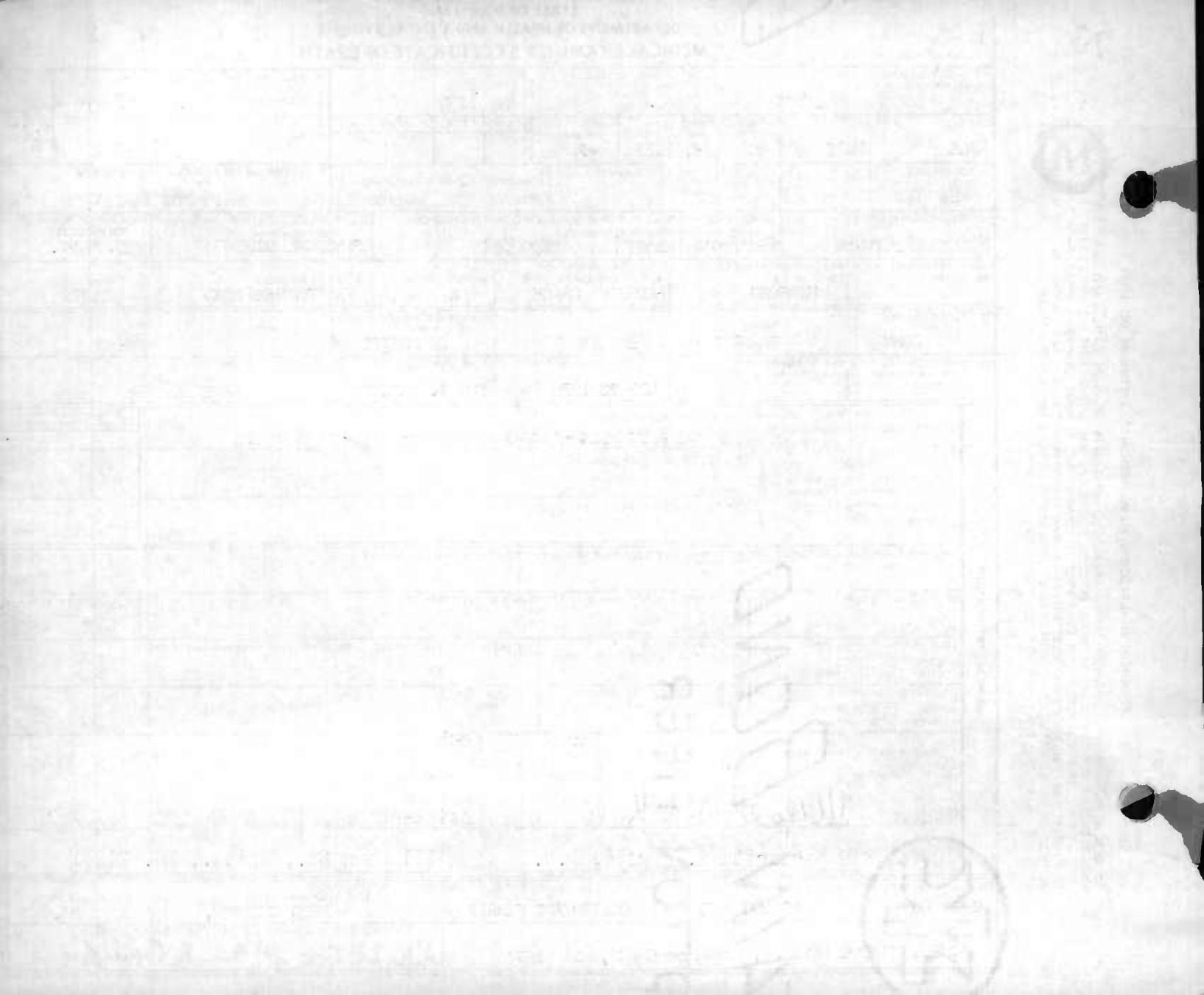


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4. RETAIN PAGE 5. REFER TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21873	
1- FOR STATE REGISTRAR		2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 8/7/83 DAY 19 YEAR 19										7b. HOUR 8:47 AM	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert			MIDDLE J.			LAST Bailey			2c. DATE PRONOUNCED DEAD 8/7/83 19 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH OCT 16, 1933			6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Havre deGrace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICAL SCIENTIST				12b. KIND OF BUSINESS OR INDUSTRY FED. GOVT.			
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 734 TYDINGS ROAD		21078			
14. FATHER'S NAME FIRST JOHN		MIDDLE FRANCIS		LAST BAILEY		15. MOTHER'S MAIDEN NAME FIRST JEANNETTE		MIDDLE		LAST FREMD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN] YES		16b. SOCIAL SECURITY NO. [IF YES, GIVE WAR OR DATES] 073 28 1530		17. INFORMANT SUE T. BAILEY		ADDRESS SAME AS #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY Body and Neck YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 8/8/83	
ACTUAL SIGNATURE <u>Margarita Korell</u>		TITLE (SPECIFY) M.D. Assistant										MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9 AUG 1983		23c. NAME OF CEMETERY OR CREMATORIAL CRATIN AND FERRIS			23d. LOCATION CITY OR TOWN WEST CHESTER,		COUNTY PA.				
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD 21078		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 15 1983 <u>John J. Canfield</u>											
20M 4/82													
DHMH - 17 (VR A15 ME (5))													



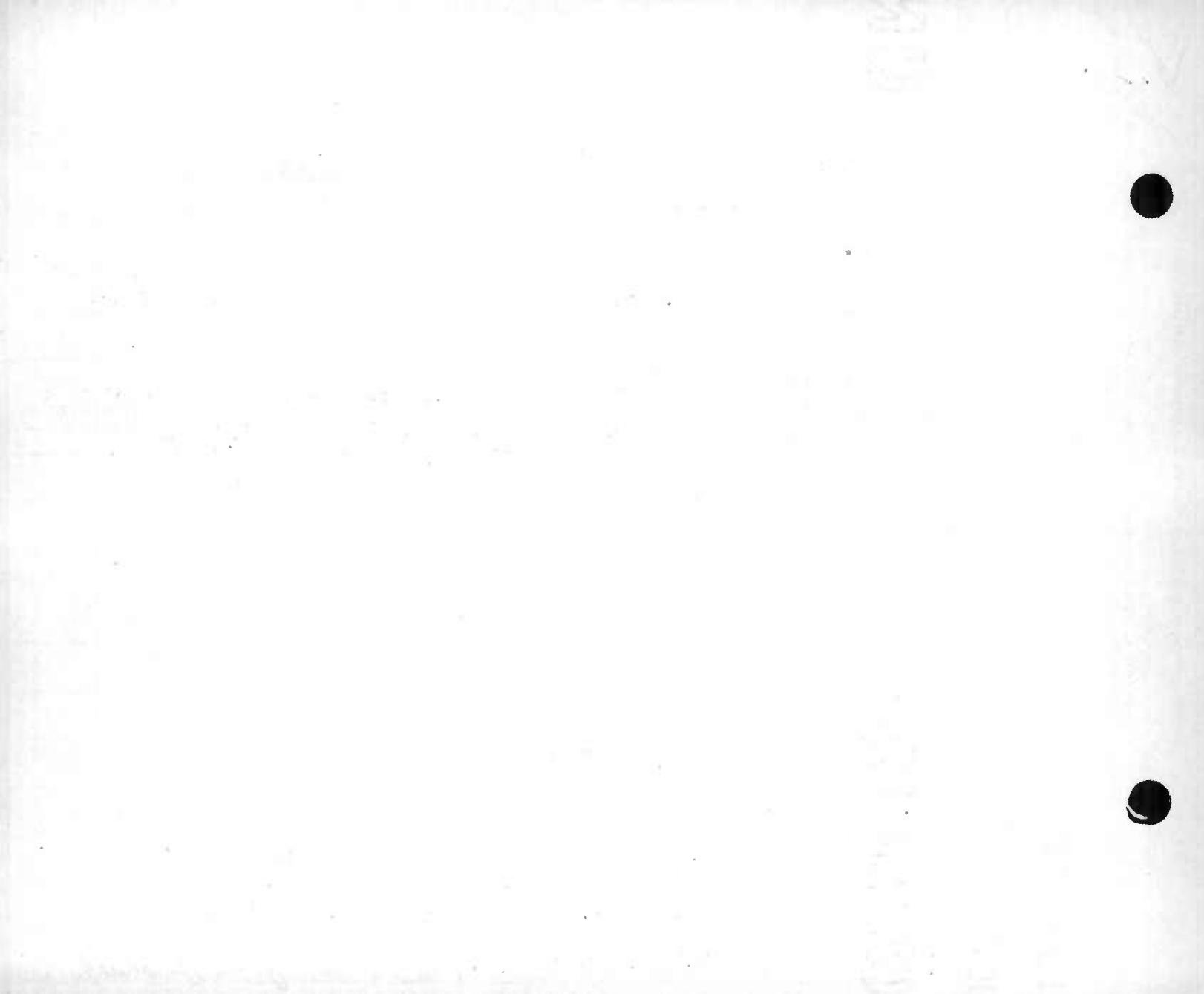
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

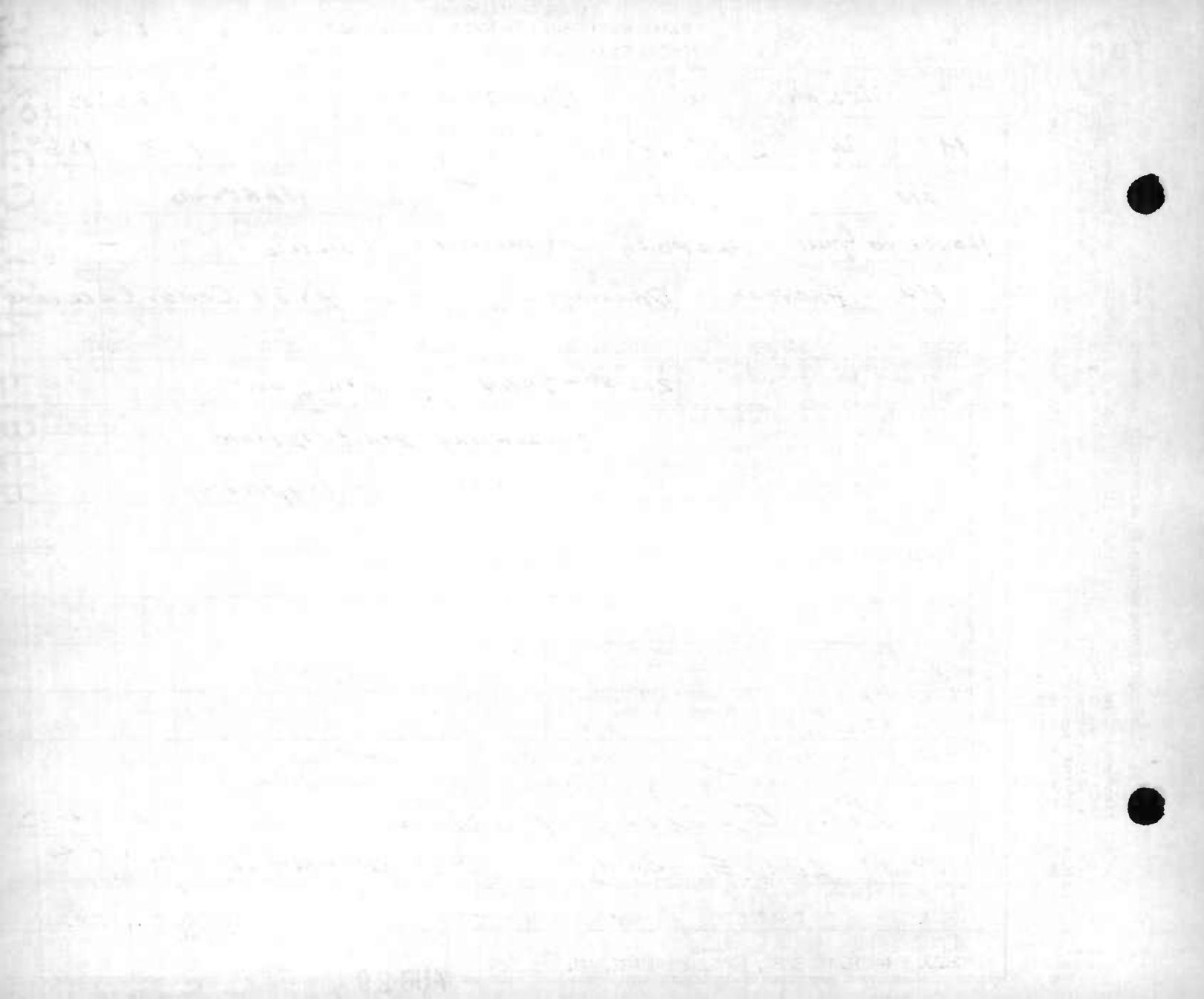
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 21874			
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
Norman J. Bannon, Sr.			August	24	1983		M	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
Male		White	Feb. 4 1902			81 yrs.	YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Harford MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Havre de Grace		Harford Memorial Hospital			Engineer			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	Railroad	
Maryland		Cecil	Port Deposit			136 N. Main St.	21904	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			12b. KIND OF BUSINESS OR INDUSTRY			
FIRST Andrew	MIDDLE	LAST Bannon	FIRST Dolly			Penn Central		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No		214-01-7984			Norman J. Bannon, Jr. Port Deposit, Md.			
18. CAUSE OF DEATH (Enter only one cause per line of Part I, b1, b2, c1, c2, d1, d2, e1, e2, f1, f2, g1, g2, h1, h2, i1, i2, j1, j2, k1, k2, l1, l2, m1, m2, n1, n2, o1, o2, p1, p2, q1, q2, r1, r2, s1, s2, t1, t2, u1, u2, v1, v2, w1, w2, x1, x2, y1, y2, z1, z2, aa1, aa2, bb1, bb2, cc1, cc2, dd1, dd2, ee1, ee2, ff1, ff2, gg1, gg2, hh1, hh2, ii1, ii2, jj1, jj2, kk1, kk2, ll1, ll2, mm1, mm2, nn1, nn2, oo1, oo2, pp1, pp2, rr1, rr2, ss1, ss2, tt1, tt2, uu1, uu2, vv1, vv2, ww1, ww2, xx1, xx2, yy1, yy2, zz1, zz2, aa3, bb3, cc3, dd3, ee3, ff3, gg3, hh3, ii3, jj3, kk3, ll3, mm3, nn3, oo3, pp3, rr3, ss3, tt3, uu3, vv3, ww3, xx3, yy3, zz3, aa4, bb4, cc4, dd4, ee4, ff4, gg4, hh4, ii4, jj4, kk4, ll4, mm4, nn4, oo4, pp4, rr4, ss4, tt4, uu4, vv4, ww4, xx4, yy4, zz4, aa5, bb5, cc5, dd5, ee5, ff5, gg5, hh5, ii5, jj5, kk5, ll5, mm5, nn5, oo5, pp5, rr5, ss5, tt5, uu5, vv5, ww5, xx5, yy5, zz5, aa6, bb6, cc6, dd6, ee6, ff6, gg6, hh6, ii6, jj6, kk6, ll6, mm6, nn6, oo6, pp6, rr6, ss6, tt6, uu6, vv6, ww6, xx6, yy6, zz6, aa7, bb7, cc7, dd7, ee7, ff7, gg7, hh7, ii7, jj7, kk7, ll7, mm7, nn7, oo7, pp7, rr7, ss7, tt7, uu7, vv7, ww7, xx7, yy7, zz7, aa8, bb8, cc8, dd8, ee8, ff8, gg8, hh8, ii8, jj8, kk8, ll8, mm8, nn8, oo8, pp8, rr8, ss8, tt8, uu8, vv8, ww8, xx8, yy8, zz8, aa9, bb9, cc9, dd9, ee9, ff9, gg9, hh9, ii9, jj9, kk9, ll9, mm9, nn9, oo9, pp9, rr9, ss9, tt9, uu9, vv9, ww9, xx9, yy9, zz9, aa10, bb10, cc10, dd10, ee10, ff10, gg10, hh10, ii10, jj10, kk10, ll10, mm10, nn10, oo10, pp10, rr10, ss10, tt10, uu10, vv10, ww10, xx10, yy10, zz10, aa11, bb11, cc11, dd11, ee11, ff11, gg11, hh11, ii11, jj11, kk11, ll11, mm11, nn11, oo11, pp11, rr11, ss11, tt11, uu11, vv11, ww11, xx11, yy11, zz11, aa12, bb12, cc12, dd12, ee12, ff12, gg12, hh12, ii12, jj12, kk12, ll12, mm12, nn12, oo12, pp12, rr12, ss12, tt12, uu12, vv12, ww12, xx12, yy12, zz12, aa13, bb13, cc13, dd13, ee13, ff13, gg13, hh13, ii13, jj13, kk13, ll13, mm13, nn13, oo13, pp13, rr13, ss13, tt13, uu13, vv13, ww13, xx13, yy13, zz13, aa14, bb14, cc14, dd14, ee14, ff14, gg14, hh14, ii14, jj14, kk14, ll14, mm14, nn14, oo14, pp14, rr14, ss14, tt14, uu14, vv14, ww14, xx14, yy14, zz14, aa15, bb15, cc15, dd15, ee15, ff15, gg15, hh15, ii15, jj15, kk15, ll15, mm15, nn15, oo15, pp15, rr15, ss15, tt15, uu15, vv15, ww15, xx15, yy15, zz15, aa16, bb16, cc16, dd16, ee16, ff16, gg16, hh16, ii16, jj16, kk16, ll16, mm16, nn16, oo16, pp16, rr16, ss16, tt16, uu16, vv16, ww16, xx16, yy16, zz16, aa17, bb17, cc17, dd17, ee17, ff17, gg17, hh17, ii17, jj17, kk17, ll17, mm17, nn17, oo17, pp17, rr17, ss17, tt17, uu17, vv17, ww17, xx17, yy17, zz17, aa18, bb18, cc18, dd18, ee18, ff18, gg18, hh18, ii18, jj18, kk18, ll18, mm18, nn18, oo18, pp18, rr18, ss18, tt18, uu18, vv18, ww18, xx18, yy18, zz18, aa19, bb19, cc19, dd19, ee19, ff19, gg19, hh19, ii19, jj19, kk19, ll19, mm19, nn19, oo19, pp19, rr19, ss19, tt19, uu19, vv19, ww19, xx19, yy19, zz19, aa20, bb20, cc20, dd20, ee20, ff20, gg20, hh20, ii20, jj20, kk20, ll20, mm20, nn20, oo20, pp20, rr20, ss20, tt20, uu20, vv20, ww20, xx20, yy20, zz20, aa21, bb21, cc21, dd21, ee21, ff21, gg21, hh21, ii21, jj21, kk21, ll21, mm21, nn21, oo21, pp21, rr21, ss21, tt21, uu21, vv21, ww21, xx21, yy21, zz21, aa22, bb22, cc22, dd22, ee22, ff22, gg22, hh22, ii22, jj22, kk22, ll22, mm22, nn22, oo22, pp22, rr22, ss22, tt22, uu22, vv22, ww22, xx22, yy22, zz22, aa23, bb23, cc23, dd23, ee23, ff23, gg23, hh23, ii23, jj23, kk23, ll23, mm23, nn23, oo23, pp23, rr23, ss23, tt23, uu23, vv23, ww23, xx23, yy23, zz23, aa24, bb24, cc24, dd24, ee24, ff24, gg24, hh24, ii24, jj24, kk24, ll24, mm24, nn24, oo24, pp24, rr24, ss24, tt24, uu24, vv24, ww24, xx24, yy24, zz24, aa25, bb25, cc25, dd25, ee25, ff25, gg25, hh25, ii25, jj25, kk25, ll25, mm25, nn25, oo25, pp25, rr25, ss25, tt25, uu25, vv25, ww25, xx25, yy25, zz25, aa26, bb26, cc26, dd26, ee26, ff26, gg26, hh26, ii26, jj26, kk26, ll26, mm26, nn26, oo26, pp26, rr26, ss26, tt26, uu26, vv26, ww26, xx26, yy26, zz26, aa27, bb27, cc27, dd27, ee27, ff27, gg27, hh27, ii27, jj27, kk27, ll27, mm27, nn27, oo27, pp27, rr27, ss27, tt27, uu27, vv27, ww27, xx27, yy27, zz27, aa28, bb28, cc28, dd28, ee28, ff28, gg28, hh28, ii28, jj28, kk28, ll28, mm28, nn28, oo28, pp28, rr28, ss28, tt28, uu28, vv28, ww28, xx28, yy28, zz28, aa29, bb29, cc29, dd29, ee29, ff29, gg29, hh29, ii29, jj29, kk29, ll29, mm29, nn29, oo29, pp29, rr29, ss29, tt29, uu29, vv29, ww29, xx29, yy29, zz29, aa30, bb30, cc30, dd30, ee30, ff30, gg30, hh30, ii30, jj30, kk30, ll30, mm30, nn30, oo30, pp30, rr30, ss30, tt30, uu30, vv30, ww30, xx30, yy30, zz30, aa31, bb31, cc31, dd31, ee31, ff31, gg31, hh31, ii31, jj31, kk31, ll31, mm31, nn31, oo31, pp31, rr31, ss31, tt31, uu31, vv31, ww31, xx31, yy31, zz31, aa32, bb32, cc32, dd32, ee32, ff32, gg32, hh32, ii32, jj32, kk32, ll32, mm32, nn32, oo32, pp32, rr32, ss32, tt32, uu32, vv32, ww32, xx32, yy32, zz32, aa33, bb33, cc33, dd33, ee33, ff33, gg33, hh33, ii33, jj33, kk33, ll33, mm33, nn33, oo33, pp33, rr33, ss33, tt33, uu33, vv33, ww33, xx33, yy33, zz33, aa34, bb34, cc34, dd34, ee34, ff34, gg34, hh34, ii34, jj34, kk34, ll34, mm34, nn34, oo34, pp34, rr34, ss34, tt34, uu34, vv34, ww34, xx34, yy34, zz34, aa35, bb35, cc35, dd35, ee35, ff35, gg35, hh35, ii35, jj35, kk35, ll35, mm35, nn35, oo35, pp35, rr35, ss35, tt35, uu35, vv35, ww35, xx35, yy35, zz35, aa36, bb36, cc36, dd36, ee36, ff36, gg36, hh36, ii36, jj36, kk36, ll36, mm36, nn36, oo36, pp36, rr36, ss36, tt36, uu36, vv36, ww36, xx36, yy36, zz36, aa37, bb37, cc37, dd37, ee37, ff37, gg37, hh37, ii37, jj37, kk37, ll37, mm37, nn37, oo37, pp37, rr37, ss37, tt37, uu37, vv37, ww37, xx37, yy37, zz37, aa38, bb38, cc38, dd38, ee38, ff38, gg38, hh38, ii38, jj38, kk38, ll38, mm38, nn38, oo38, pp38, rr38, ss38, tt38, uu38, vv38, ww38, xx38, yy38, zz38, aa39, bb39, cc39, dd39, ee39, ff39, gg39, hh39, ii39, jj39, kk39, ll39, mm39, nn39, oo39, pp39, rr39, ss39, tt39, uu39, vv39, ww39, xx39, yy39, zz39, aa40, bb40, cc40, dd40, ee40, ff40, gg40, hh40, ii40, jj40, kk40, ll40, mm40, nn40, oo40, pp40, rr40, ss40, tt40, uu40, vv40, ww40, xx40, yy40, zz40, aa41, bb41, cc41, dd41, ee41, ff41, gg41, hh41, ii41, jj41, kk41, ll41, mm41, nn41, oo41, pp41, rr41, ss41, tt41, uu41, vv41, ww41, xx41, yy41, zz41, aa42, bb42, cc42, dd42, ee42, ff42, gg42, hh42, ii42, jj42, kk42, ll42, mm42, nn42, oo42, pp42, rr42, ss42, tt42, uu42, vv42, ww42, xx42, yy42, zz42, aa43, bb43, cc43, dd43, ee43, ff43, gg43, hh43, ii43, jj43, kk43, ll43, mm43, nn43, oo43, pp43, rr43, ss43, tt43, uu43, vv43, ww43, xx43, yy43, zz43, aa44, bb44, cc44, dd44, ee44, ff44, gg44, hh44, ii44, jj44, kk44, ll44, mm44, nn44, oo44, pp44, rr44, ss44, tt44, uu44, vv44, ww44, xx44, yy44, zz44, aa45, bb45, cc45, dd45, ee45, ff45, gg45, hh45, ii45, jj45, kk45, ll45, mm45, nn45, oo45, pp45, rr45, ss45, tt45, uu45, vv45, ww45, xx45, yy45, zz45, aa46, bb46, cc46, dd46, ee46, ff46, gg46, hh46, ii46, jj46, kk46, ll46, mm46, nn46, oo46, pp46, rr46, ss46, tt46, uu46, vv46, ww46, xx46, yy46, zz46, aa47, bb47, cc47, dd47, ee47, ff47, gg47, hh47, ii47, jj47, kk47, ll47, mm47, nn47, oo47, pp47, rr47, ss47, tt47, uu47, vv47, ww47, xx47, yy47, zz47, aa48, bb48, cc48, dd48, ee48, ff48, gg48, hh48, ii48, jj48, kk48, ll48, mm48, nn48, oo48, pp48, rr48, ss48, tt48, uu48, vv48, ww48, xx48, yy48, zz48, aa49, bb49, cc49, dd49, ee49, ff49, gg49, hh49, ii49, jj49, kk49, ll49, mm49, nn49, oo49, pp49, rr49, ss49, tt49, uu49, vv49, ww49, xx49, yy49, zz49, aa50, bb50, cc50, dd50, ee50, ff50, gg50, hh50, ii50, jj50, kk50, ll50, mm50, nn50, oo50, pp50, rr50, ss50, tt50, uu50, vv50, ww50, xx50, yy50, zz50, aa51, bb51, cc51, dd51, ee51, ff51, gg51, hh51, ii51, jj51, kk51, ll51, mm51, nn51, oo51, pp51, rr51, ss51, tt51, uu51, vv51, ww51, xx51, yy51, zz51, aa52, bb52, cc52, dd52, ee52, ff52, gg52, hh52, ii52, jj52, kk52, ll52, mm52, nn52, oo52, pp52, rr52, ss52, tt52, uu52, vv52, ww52, xx52, yy52, zz52, aa53, bb53, cc53, dd53, ee53, ff53, gg53, hh53, ii53, jj53, kk53, ll53, mm53, nn53, oo53, pp53, rr53, ss53, tt53, uu53, vv53, ww53, xx53, yy53, zz53, aa54, bb54, cc54, dd54, ee54, ff54, gg54, hh54, ii54, jj54, kk54, ll54, mm54, nn54, oo54, pp54, rr54, ss54, tt54, uu54, vv54, ww54, xx54, yy54, zz54, aa55, bb55, cc55, dd55, ee55, ff55, gg55, hh55, ii55, jj55, kk55, ll55, mm55, nn55, oo55, pp55, rr55, ss55, tt55, uu55, vv55, ww55, xx55, yy55, zz55, aa56, bb56, cc56, dd56, ee56, ff56, gg56, hh56, ii56, jj56, kk56, ll56, mm56, nn56, oo56, pp56, rr56, ss56, tt56, uu56, vv56, ww56, xx56, yy56, zz56, aa57, bb57, cc57, dd57, ee57, ff57, gg57, hh57, ii57, jj57, kk57, ll57, mm57, nn57, oo57, pp57, rr57, ss57, tt57, uu57, vv57, ww57, xx57, yy57, zz57, aa58, bb58, cc58, dd58, ee58, ff58, gg58, hh58, ii58, jj58, kk58, ll58, mm58, nn58, oo58, pp58, rr58, ss58, tt58, uu58, vv58, ww58, xx58, yy58, zz58, aa59, bb59, cc59, dd59, ee59, ff59, gg59, hh59, ii59, jj59, kk59, ll59, mm59, nn59, oo59, pp59, rr59, ss59, tt59, uu59, vv59, ww59, xx59, yy59, zz59, aa60, bb60, cc60, dd60, ee60, ff60, gg60, hh60, ii60, jj60, kk60, ll60, mm60, nn60, 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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	21875										
1- STATE REGISTRAR																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR					
Joseph			W			BARTLEBAUGH						<input type="checkbox"/> 823 19 83			1 PM			M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY) YRS.)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
M		W		2 15 48			35			MONTHS		DAYS		8 23 19 83			19 13 60			M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md			USA																		HARFORD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace			Harford Memorial									Pipe fitter			Power Plant								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21034									
Md			Harford		Dwellington						3434 Cedar Cheneau												
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			LAST								
			JAMES			WARREN			BARTLEBAUGH			MARY			McCLURE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			ADDRESS								
NO			212-50-7444									MRS. CORA BARTLEBAUGH			SAME AS #13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 19a. DATE OF OPERATION															19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															DATE SIGNED <i>8-24-83</i>								
ACTUAL SIGNATURE		<i>Luis E. Renjel</i> M.D. Deputy MEDICAL EXAMINER																					
EXAMINER'S NAME (TYPE OR PRINT)		<i>Luis E. Renjel</i> ADDRESS <i>464 Orleans St Havre de Grace</i>																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
BURIAL			26AUGUST83			BAPTIST VIEW CEMETERY			HARFORD CO., MARYLAND														
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078															25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
															<i>AUG 29 1983 John J. Carroll</i>								
BP																							
DHMH-17 (VRA15 ME (5)) 15M 2/80																							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 | 876

REG. NO.

1-
FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE

KNOWN

MONTH

DAY

YEAR

2b. HOUR

Peter L.

Bryant

8 13 19 83

M

3. SEX
Male

4. RACE
White

5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 12, 1941

6. AGE (IN YEARS
LAST BIRTHDAY)
42 yrs.

7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN

8. DATE
PRONOUNCED
DEAD
8 13 19 83

MONTH DAY YEAR
1:47 a.m.

M

9. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Massachusetts

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH
Harford County,

M.D.

10. CITY OR TOWN OF DEATH
Fallston

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Line Foreman C&P Telephone

13a. STATE
Maryland

13b. COUNTY
Baltimore

13c. CITY OR TOWN
Baldwin

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS
13810 Baldwin Mill Road

2013

M.D.

14. FATHER'S NAME
FIRST MIDDLE LAST

Thomas F. Bryant, Sr.

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Jean Sheldon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

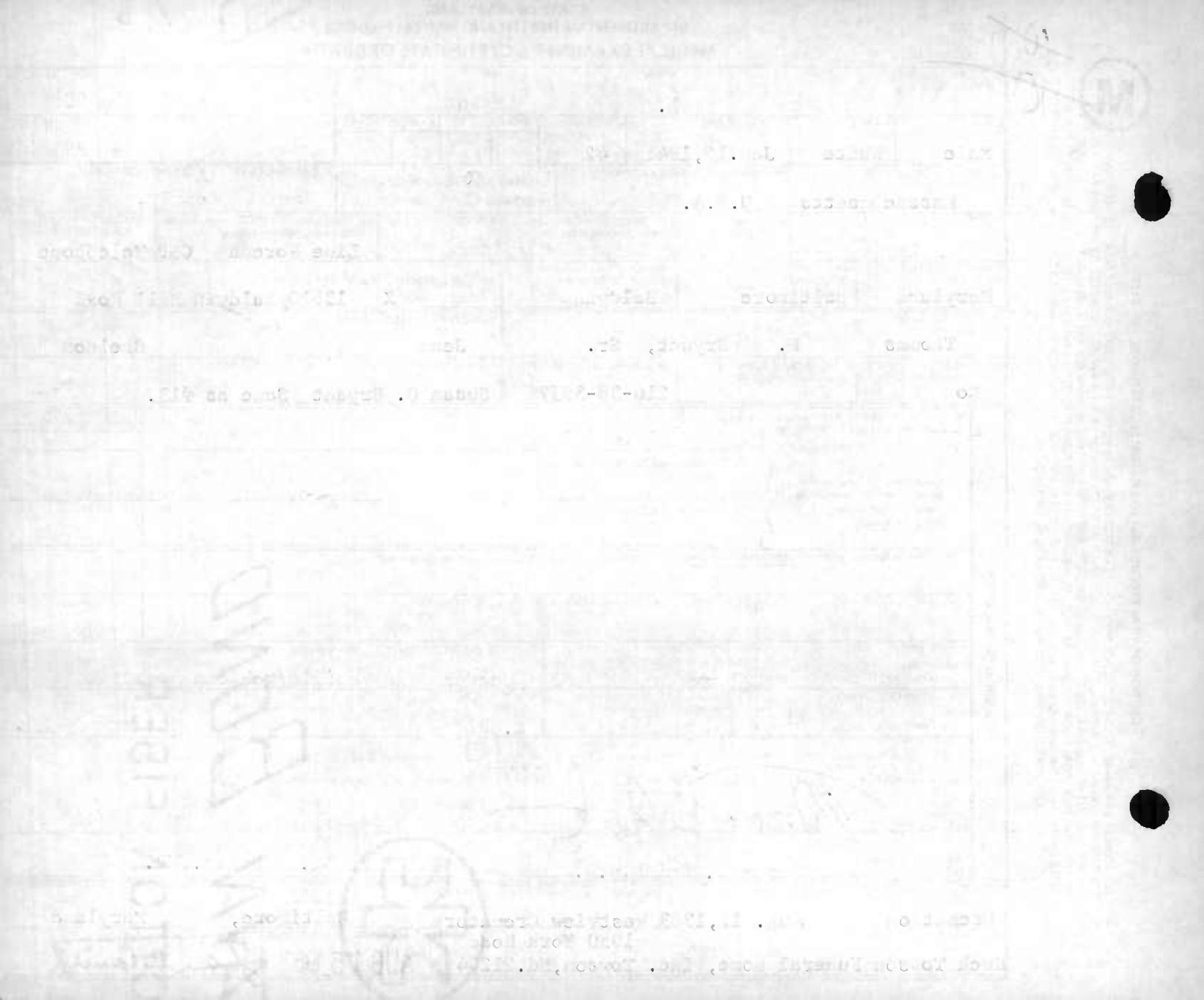
16b. SOCIAL SECURITY NO.

216-38-3957

17. INFORMANT

Susan O. Bryant Same as #13.

ADDRESS



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN DEATH ESTD. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
LIL BURN			Clay	BUSH		Aug. 22 83 10:55 AM						
35	2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (YEARS) MONTHS	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. HOURS	9. IF OVER 65 YEARS	10. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	11. HOURS
35	M	W	9 25 18	64				19				
35	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
35	Maryland	U.S.A.				Harford						
120	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
120	FALLSTON	FALLSTON GEN. Hos.			Chief Ticket Agent			Railroad				
120	13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
120	MD	HARFORD	FALLSTON	203 MOUNTAIN RD.			203 Mountain Rd.					
1	14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
1	David		Bush	Mae				Smith				
1	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			20. AUTOPSY?						
1	No	214-18-5614	Faye W. Bush			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
1	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ATHEROSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). THROMBOEMBOLIC PULMONARY EMBOLUS, COPD.											
1	19a. DATE OF OPERATION 1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? PERFORATED PELVIC DIVERTICULUM			20. AUTOPSY?					
1	21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A					
1	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
1	22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
1	ACTUAL SIGNATURE <u>Ganesha Prabhu</u> M.D. TITLE (SPECIFY) <u>MEDICAL EXAMINER</u> DATE SIGNED <u>AUG 22 83</u>											
1	EXAMINER'S NAME (TYPE OR PRINT) GANESH S. PRABHU			ADDRESS 200 MILTON AVE FALLSTON 21047								
1	23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1 Aug 25, 83	Upper Cross Roads BAPTIST CHURCH CEM.			Upper Cross Roads CITY OR TOWN COUNTY STATE Harford Md.					
1	24. FUNERAL DIRECTOR Foster Funeral Home William E. Collins			W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR AUG 29 1983					
1							25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>					
BP	DHMH-17 (VRA15 ME(5)) 15M 2/80											

Obtained

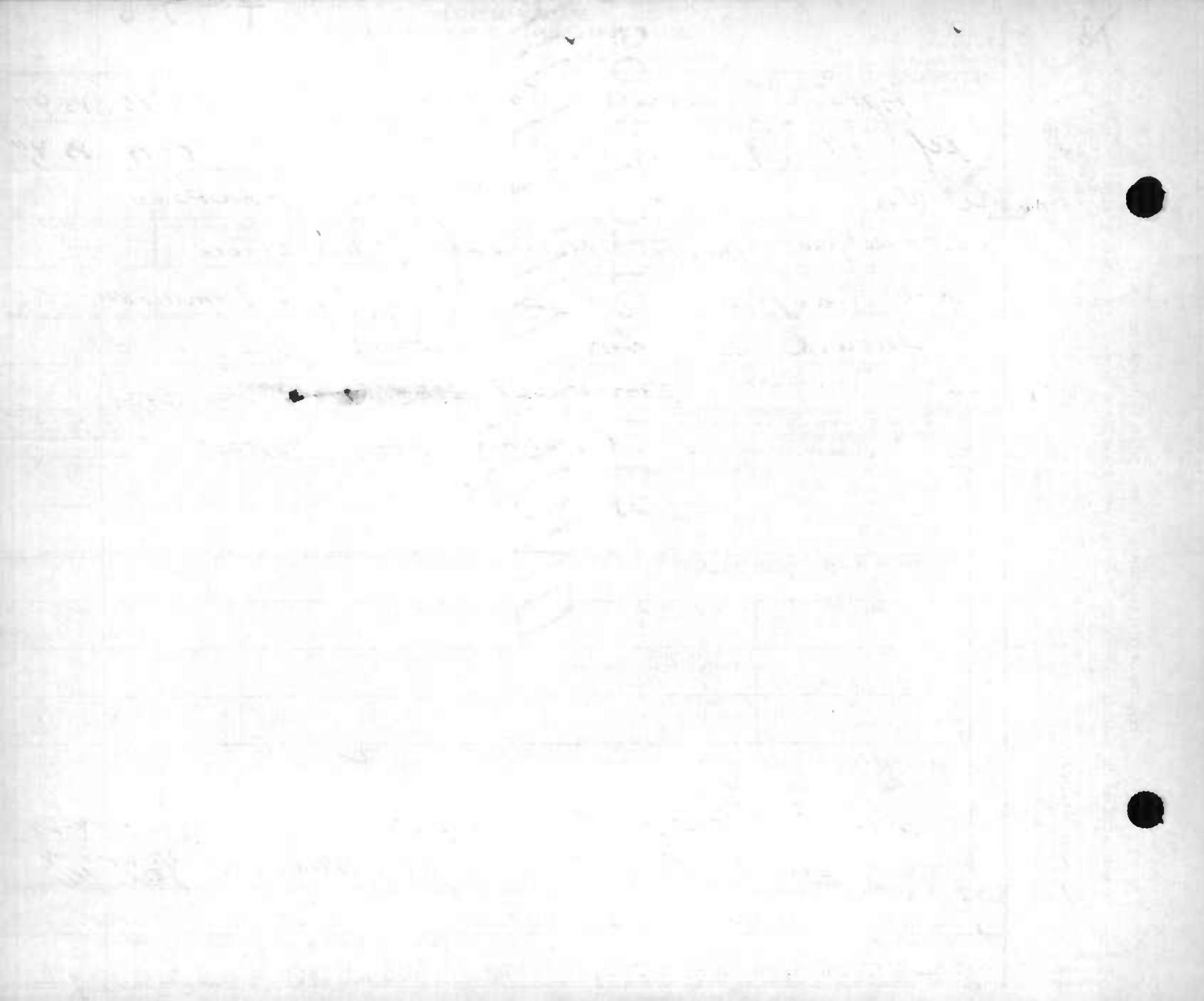
from the small town

population 500

Classification

FOR
1- STATE
REGISTRAR
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W.
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
ARTHUR			Lee	Cawley		8-13	19	13	8:15	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS	IF UNDER 1 YR. HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Male	W	9 10 29	53 yrs.			8-13	19	13	8:15	M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		USA						Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace		Harford Hospital			Enginner			Hospital					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.			
Md		Harford		Havre de Grace		No		1704 Glenville Rd.		21078			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Howard		Lee		Cawley		Frances		MARIE		McGRAW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT MRS. RAE CAWLEY		ADDRESS						
YES		233-42-1258			11		242-2-1258		SAME AS #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <u>Douglas</u> MEDICAL EXAMINER										DATE SIGNED <u>8-14-83</u>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>464 Allaire St</u>										<u>Havre de Grace Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE CREMATION		23c. NAME OF CEMETERY OR CREMATORIAL CRATIN AND FERRIS			23d. LOCATION CITY OR TOWN WEST CHESTER,			COUNTY	STATE	
15 AUGUST 83												PENN.	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, PA HAVRE de GRACE, MD 21078												25a. DATE REC'D. BY REGISTRAR AUG 18 1983	
												25b. REGISTRAR'S SIGNATURE <u>Selma J. Cawley</u>	

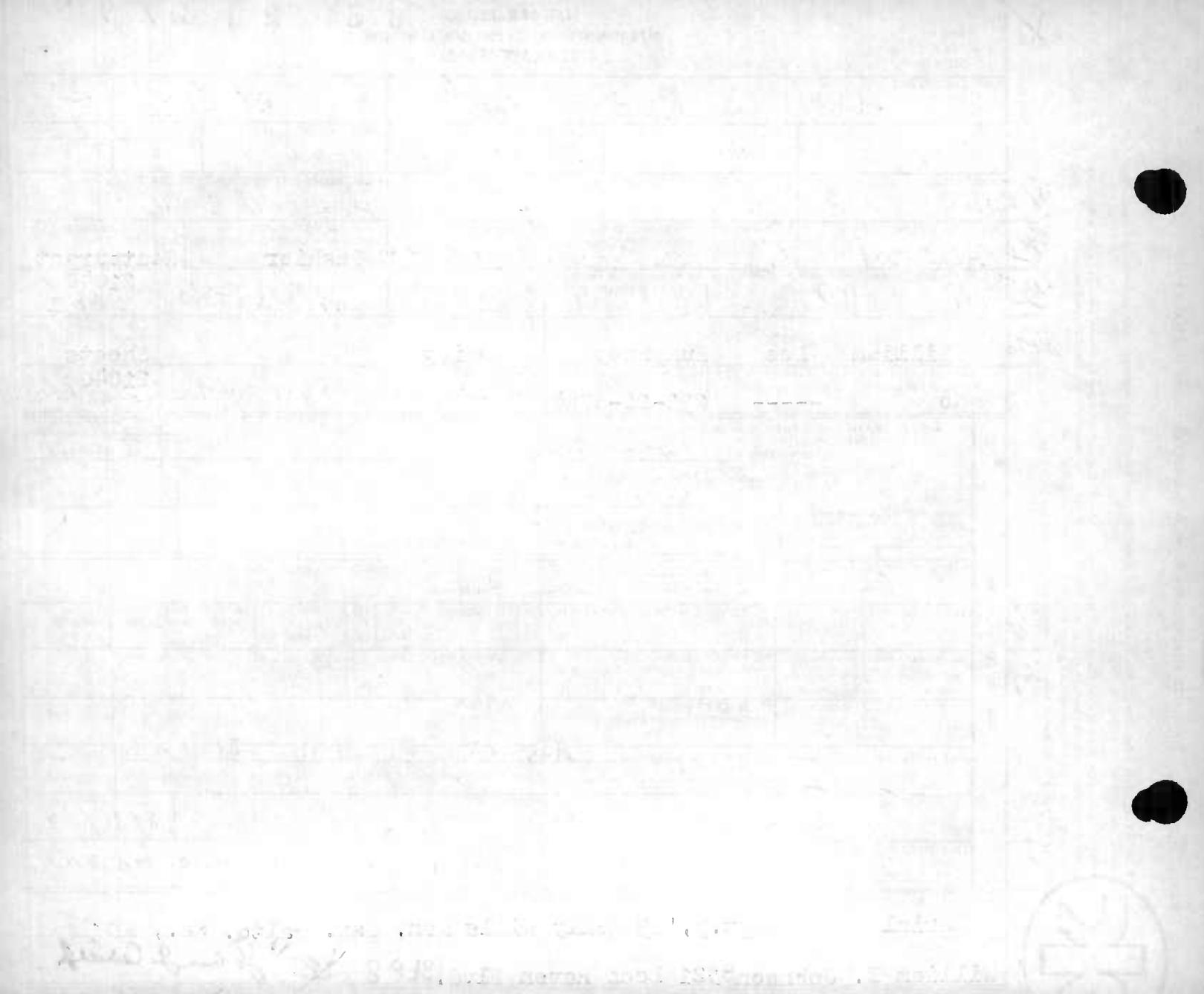


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of her death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8321879		
												REG. NO.		
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			MARY LUCILLE CAYNOR						08 31 83			1:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
FEMALE		W		12 21 20			62			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
W. VIRGINIA		U.S.					HARFORD COUNTY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
BELLSTON		PRESTON GENERAL HOSPITAL		Cashier			Restaurant							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21040		
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN FOGWOOD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 609 HARTWOOD LANE				
14. FATHER'S NAME FIRST William		MIDDLE Lee		LAST Humphrey			15. MOTHER'S MAIDEN NAME FIRST Daisy			MIDDLE			LAST Sheets	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			21040				
No		232-20-6784		SHEILA RICE 609 HARTWOOD LANE										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Ventricular fibrillation</u>												11		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>												11		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Obstructive Pulmonary Disease</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 29 1983</u> to <u>Aug. 31 1983</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 31 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>A.J. Sweatman</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/31/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.J. SWEATMAN MD			22e. ADDRESS Faison General Hosp MD 21047											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 3, '83			23c. NAME OF CEMETERY OR CREMATORIAL Holly Hills Mem. Gar. Balto. Co., MD			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24. FUNERAL DIRECTOR NAME William E. Johnson			ADDRESS 8521 Loch Raven Blvd.			25a. DATE REC'D. BY REGISTRAR SEP 2 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Coughlin</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

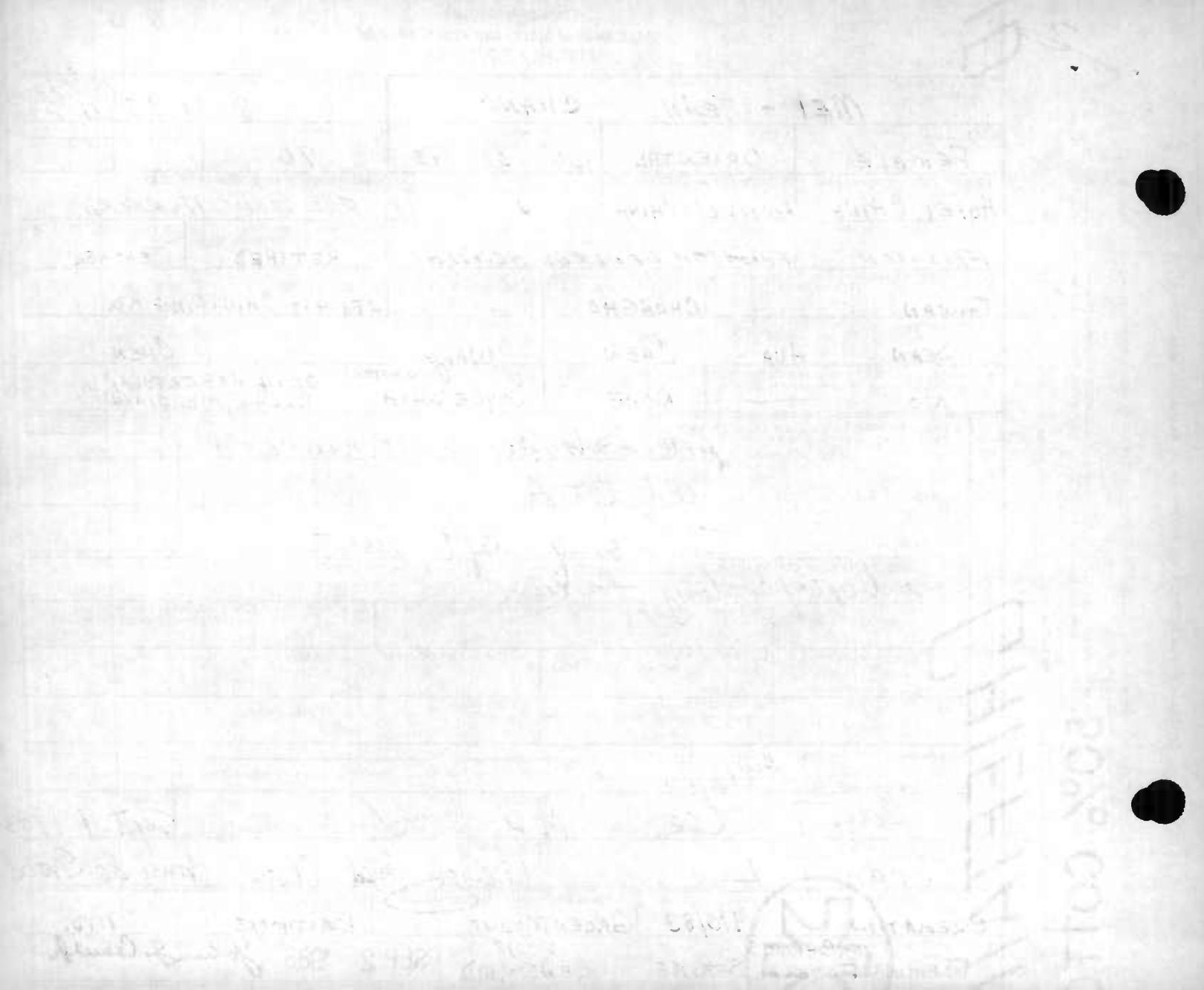
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached from one on the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21380

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>MEI - JEAN CHANG</i>						<i>8 31 83</i>				<i>11 33 P.M.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>FEMALE</i>		<i>ORIENTAL</i>		MONTH <i>06</i>	DAY <i>03</i>	YEAR <i>13</i>	70	MONTHS YRS.	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>HOPEI, CHINA</i>		<i>REPUBLIC OF CHINA</i>				<i>FALLSTON - HARFORD MD.</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>FALLSTON</i>		<i>FALLSTON GENERAL HOSPITAL</i>		<i>RETIRED</i>		<i>TEACHER</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
<i>TAIWAN</i>				<i>CHUNGHO</i>				<i>211 414 CHIN-PING RD. 99999</i>			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST
		<i>SEAN</i>	<i>HUA</i>	<i>CHEN</i>	<i>WANG</i>						<i>CHEN</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (DAUGHTER)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>		<i>NONE</i>		<i>Joyce Shih</i>		<i>2014 ROBERTSON RD. BELAIR, MD. 21014</i>					
18. CAUSE OF DEATH (Enter only one cause per line for part I, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>											
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>old CVA</i> (c) <i>Tumor of left jaw</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Cardiovascular failure</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on Aug. 31 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jean T. Lee</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>Sept. 1, 1983</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jean T. Lee</i>		22f. ADDRESS <i>Union Med. Clinic - Hanse de Grace</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>9/3/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>GREENMOUNT</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>E. Barnes</i>		ADDRESS <i>21018 BENSON, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 2 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John Barnes</i>					
FLEMING FUNERAL SERVICE											

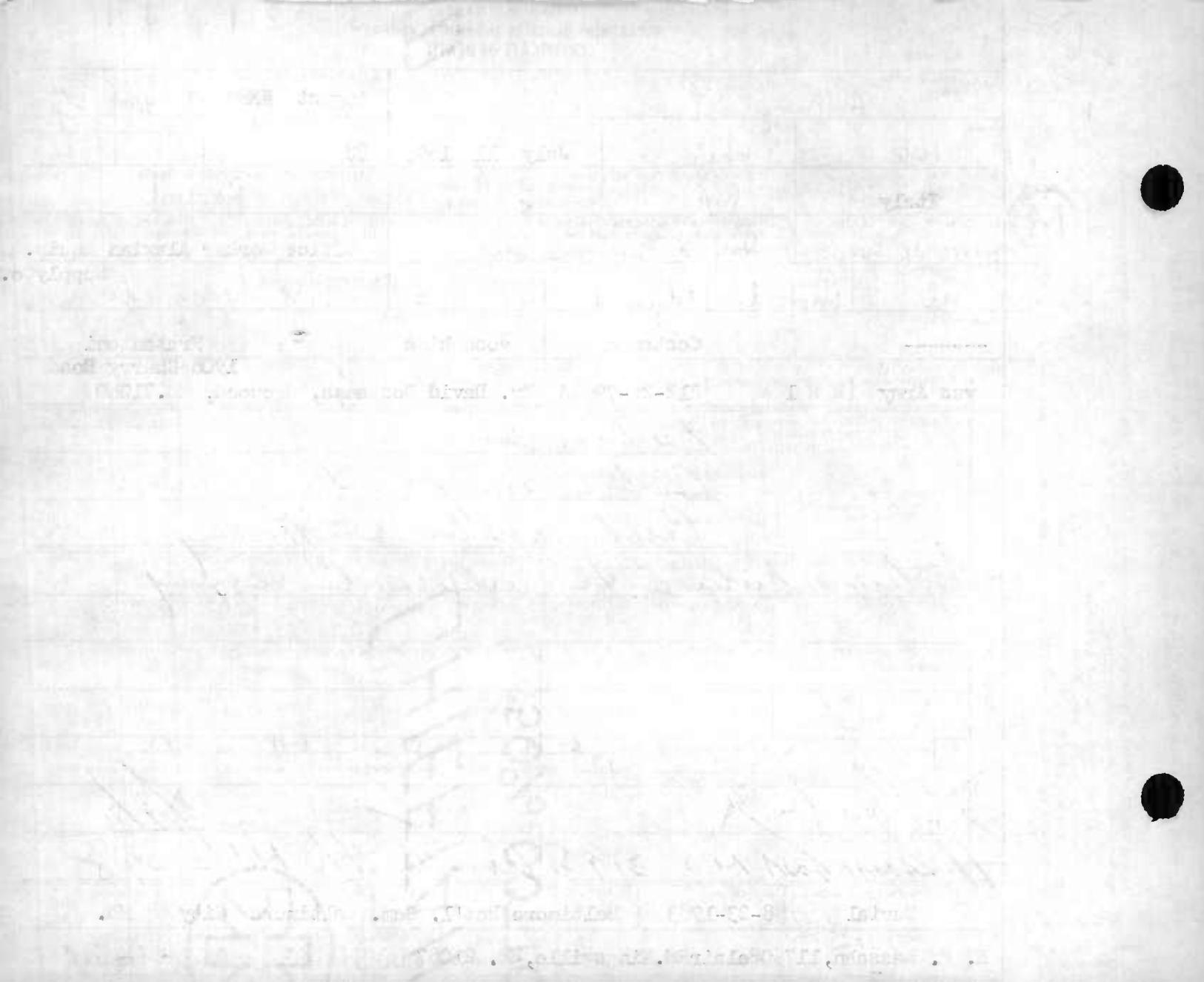


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21881		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Anthony J. Costanza						August 19 1983			5:26 p.m.		
3 SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			white			July 11 1895			88					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Italy			USA						Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Harford			Harford Memorial Hosp						Office Worker			Alexian Equip. & Supply Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Md.			Harford			Edgewood						1908 Cherry Rd. 21040		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John J. Costanza			Josephine Fratantoni											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes Army			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			1908 Cherry Road		
			212-26-7964A			Mr. David Costanza, Edgewood, Md. 21040								
18 CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4379 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial decompression</u> (c) <u>Cerebrovascular insufficiency</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>arteriosclerosis arterio & cerebral thrombosis</u>														
19a. MEDICAL CERTIFICATE			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-19, 1983, to 8-9, 1983, that (I) (we) last saw the deceased alive on 8-9, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.														
22b. SIGNATURE			22c. DEGREE									22d. DATE SIGNED		
22e. ATTENDING PHYSICIAN (TYPE OR PRINT)			22f. MEDICAL DIRECTOR (TYPE OR PRINT)			22g. STAFF PHYSICIAN (TYPE OR PRINT)								
John J. Costanza M.D. 319 So. Union St. Md. 21078														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		
Burial			8-23-1983			Baltimore Nat'l. Cem.			Baltimore City			Md.		
24. FUNERAL DIRECTOR E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087														
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

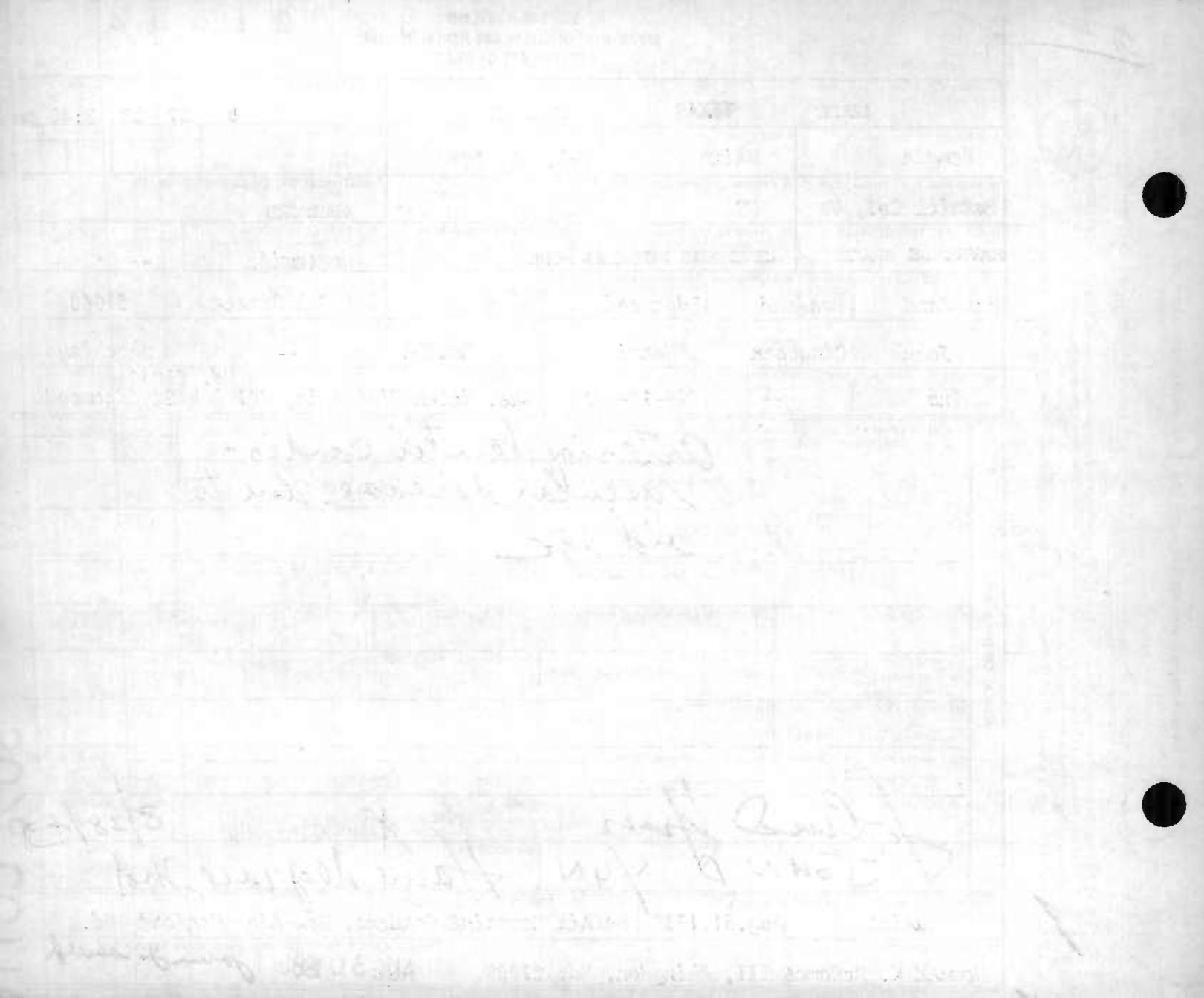
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 21882

1 - FOR STATE REGISTRAR				REG. NO.			
I. DECEASED NAME (TYPE OR PRINT)		FIRST LUCY	MIDDLE TEXAS	LAST COULSON	20. DATE OF DEATH MONTH DAY YEAR	MONTH 8 DAY 27 YEAR 83	DAY YEAR 3:40 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1900		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Patrick Co., Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 401 Oak Street		13f. ZIP CODE 21040		14. FATHER'S NAME FIRST John MIDDLE Clayborn LAST Harris		15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE -- LAST Shockley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Helen Gillespie, 401 Oak St, Edgewood		ADDRESS Md. 21040	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardio-</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Vascular disease due to</i> (c) <i>old age</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John J. Yun</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. ADDRESS <i>Havre de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 31, 1983		23c. NAME OF CEMETERY OR CREMATORIAL BelAir Memorial Gardens, Bel Air Harford Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Yun</i>	



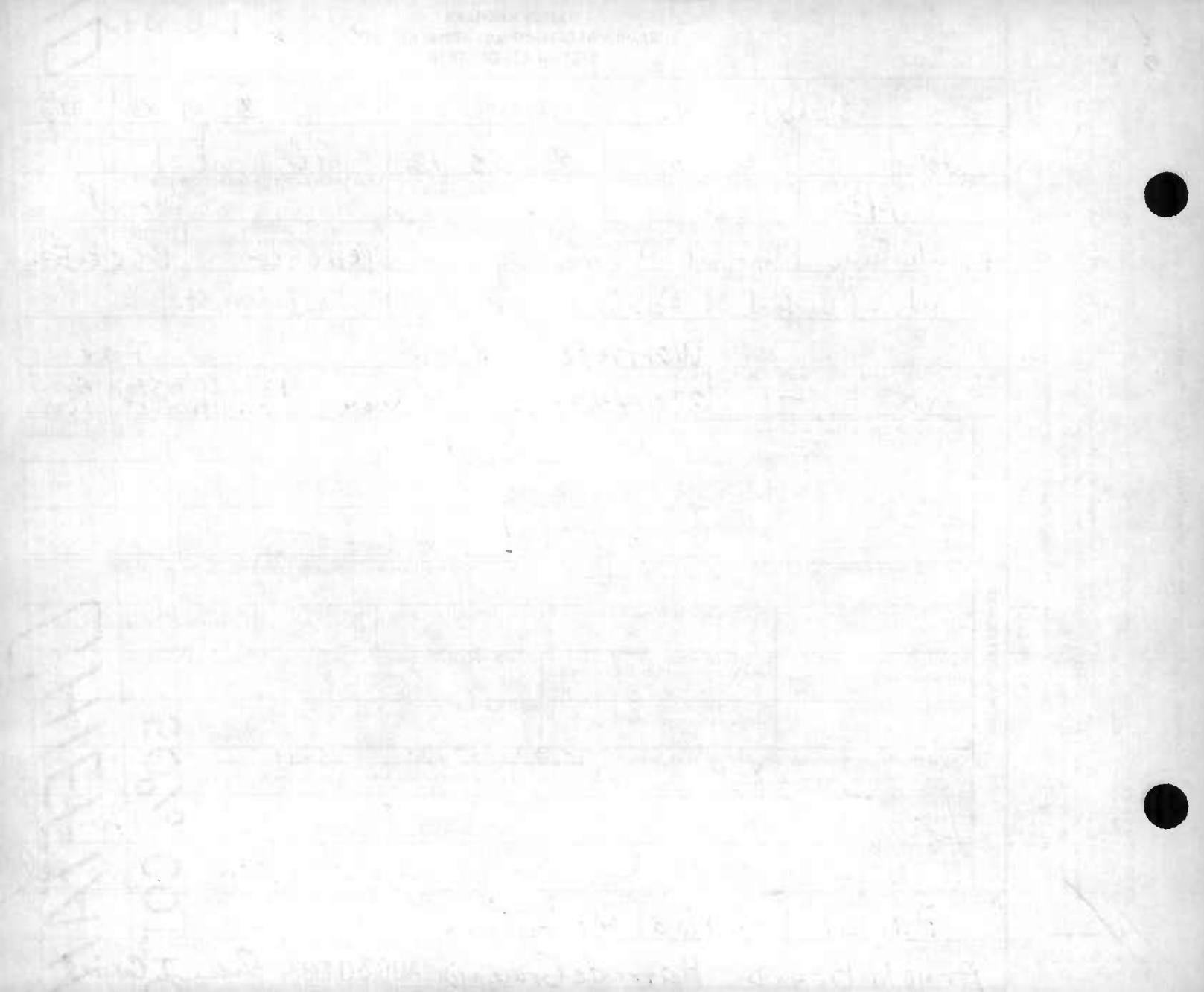
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21583										
1 - STATE REGISTRAR			2a. DATE OF DEATH 8 19 83							2b. HOUR 10 15 PM										
1. DECEASED NAME (TYPE OR PRINT) Elizabeth W.			MIDDLE Davage			LAST		3. SEX Female		4. RACE Black		5. DATE OF BIRTH 8 23 12			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.												
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Harford Memorial Hosp			(IF NOT INSUR FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION Teacher			12b. KIND OF BUSINESS OR INDUSTRY Bd. of Ed.									
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 423 Oak St. 21001									
14. FATHER'S NAME FIRST _____ MIDDLE _____ LAST _____			15. MOTHER'S MAIDEN NAME First Rosalie Middle _____ LAST _____			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 230-14-1099			17. INFORMANT Helia Jackson		ADDRESS 1314 Winston Ave. Baltimore, MD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line in Part 1 and Part 2). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360			DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis			DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 7-31, 1983, to 8-19, 1983, that (I) (we) last saw the deceased alive on 8-19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										22b. DATE SIGNED 8/20/83										
22c. SIGNATURE Dante Mungar			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dante Mungar			22e. ADDRESS 622 L Union Ave Havre de Grace Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/21/83			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
24. FUNERAL DIRECTOR NAME Arnold Beard			ADDRESS Hayre de Grace, MD			25a. DATE REC'D. BY REGISTRAR AUG 30 1983			25b. REGISTRAR'S SIGNATURE John G. Canfield											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign.

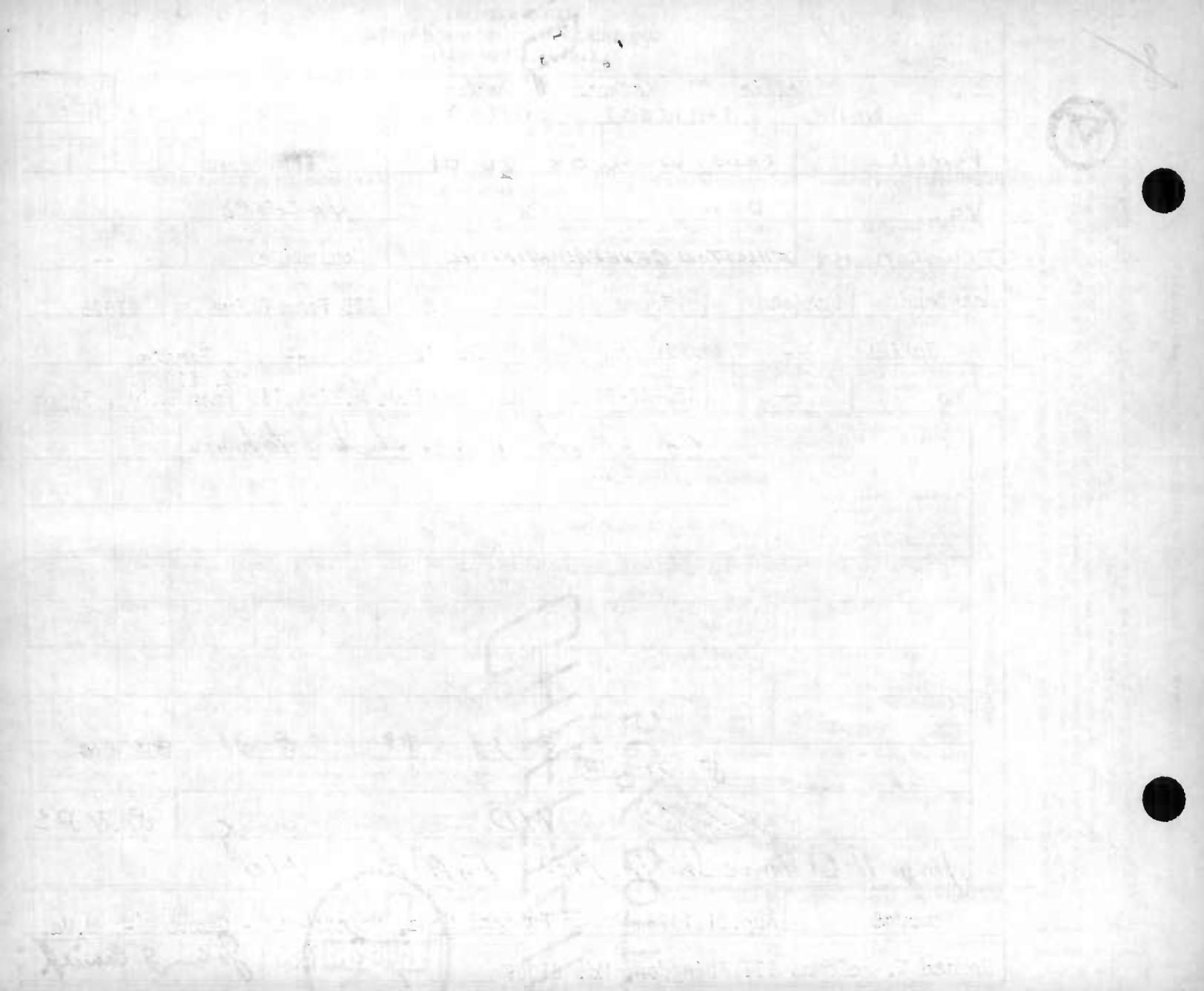
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21384									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Nellie	MIDDLE Kathern	LAST Dayton					08 21 83		6:15 PM								
Nellie KATHERN DAYTON																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		cauc - white		MONTH 08	DAY 26	YEAR 01	81		MONTHS	DAYS	HOURS	MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Va.		U.S.A.				Harford		Md.				FALLSTON, Md.		FALLSTON GENERAL HOSPITAL		Housewife		--	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST Julius				MIDDLE Dettinburn		LAST Feaster			
Maryland		Harford		Joppa				115 Fern Drive								21085			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
no		235-60-32550		Mrs. Genevieve M. Zirk, 115 Fern Drive, Joppa		1790													
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8-21-83 to 8-21-83, that (we) lost saw the deceased alive an above, (if (we) did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		MD.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 8-21-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Fallston, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Aug. 21, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Arnold Funeral Home, Petersburg - Grant		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE									
						W. Va.													
24. FUNERAL DIRECTOR NAME Howard K. McComas III Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 23 1983		25b. REGISTRAR'S SIGNATURE John G. Conner													



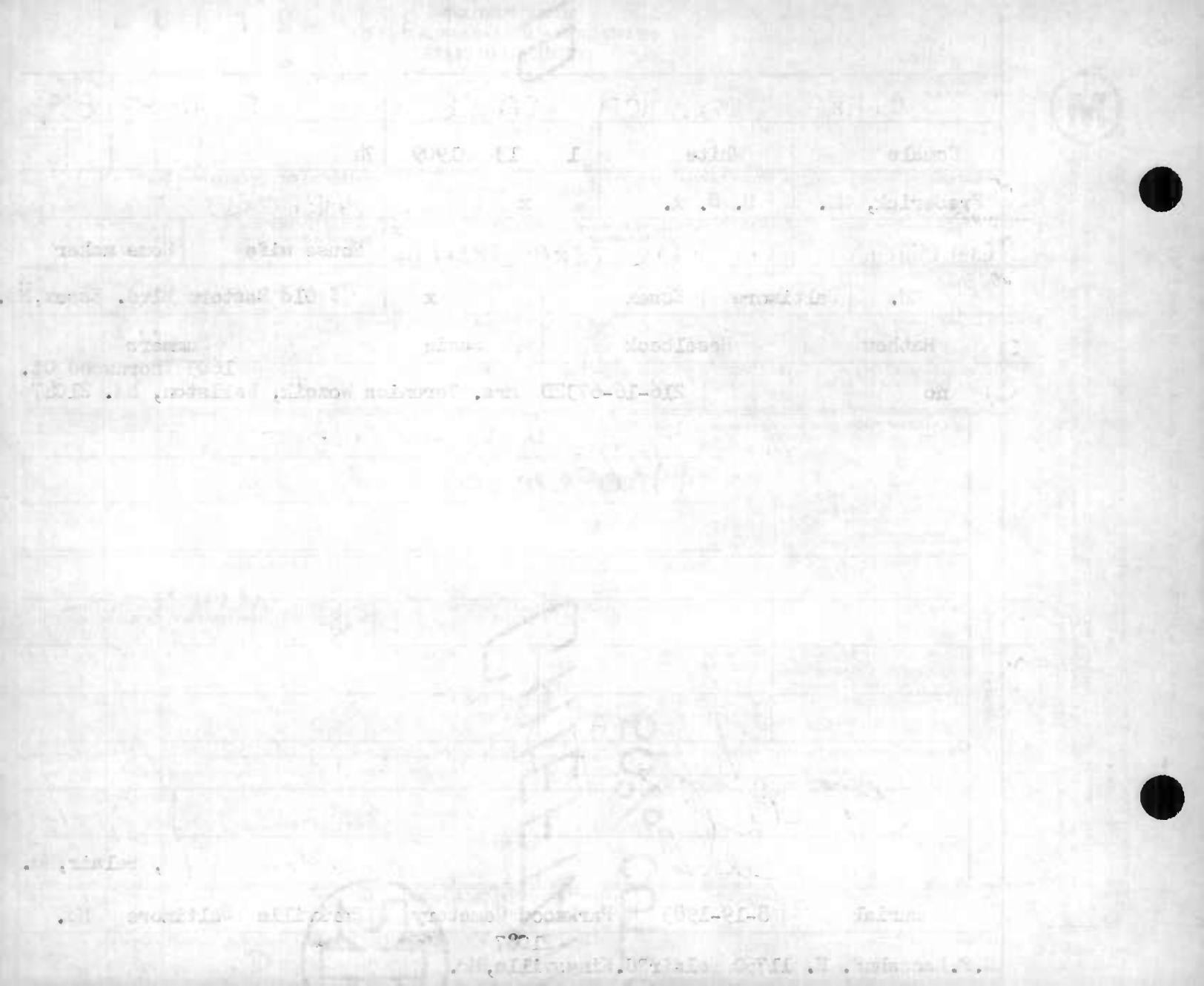
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21885					
1 - STATE REGISTRAR			I. DECEASED NAME FIRST CHARA MIDDLE VERONICA LAST EARLE							2a. DATE OF DEATH MONTH DAY YEAR 8 16 83		2b. HOUR 8:43			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 1 DAY 13 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.							
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION House wife		12b. KIND OF BUSINESS OR INDUSTRY Home maker							
13a. STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Old Eastern Blvd. Essex, Md.					
14. FATHER'S NAME FIRST Mathew MIDDLE MIDDLE Haselbeck LAST			15. MOTHER'S MAIDEN NAME FIRST Susie MIDDLE Summers LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-16-6732D		17. INFORMANT Mrs. Veronica Wozcik, Fallston, Md. 21047		ADDRESS 1603 Thornwood Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1550										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) Urosepsis															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21g. DEGREE		22e. ADDRESS							
22a. I certify that (1) (this hospital) attended the deceased from 8/10/83 to 8/16/83, and that (1) (we) lost saw the deceased alive on 8/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body of the deceased.			22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/12/83		22d. LOCATION CITY OR TOWN Parkville		COUNTY Baltimore		STATE Md.			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) LIVPA FRED			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-19-1983		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION CITY OR TOWN Parkville		COUNTY Baltimore		STATE Md.	
24. FUNERAL DIRECTOR NAME E.F. Iassahn F. H. ADDRESS 21087			25a. DATE REC'D. BY REGISTRAR AUG 22 1983			25b. REGISTRAR'S SIGNATURE See 2 Cared									
DHHM - 16 50M 4/B2 (VRA 15, 4)															

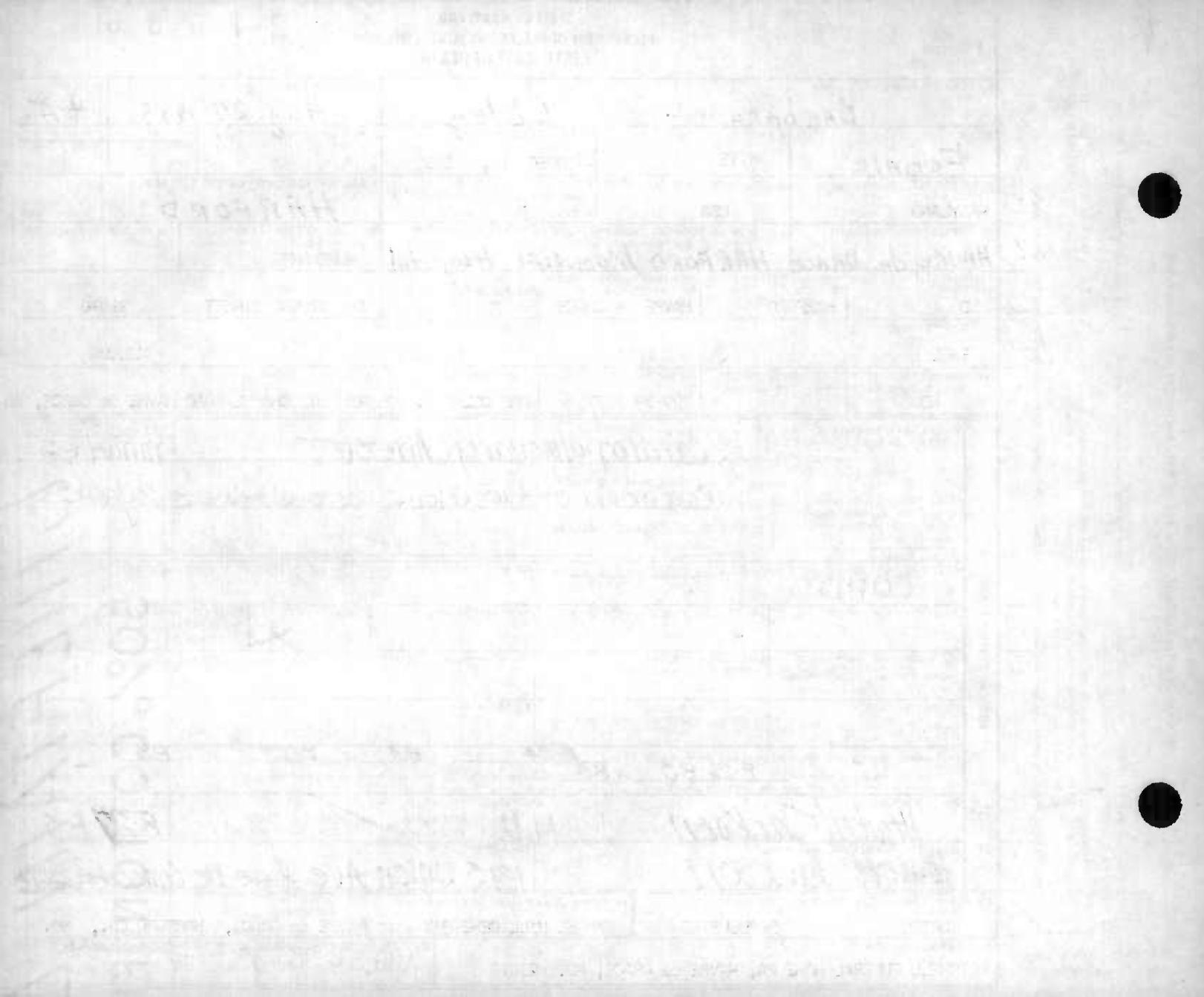


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8321886		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR Aug. 27, 1983									2b. HOUR 4 PM		
1. DECEASED NAME (TYPE OR PRINT) BARBARA L. Ebley			MIDDLE			LAST								
3. SEX Female			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 13, 1932			6. AGE (IN YEARS & MONTHS) 50 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD					
10. CITY OR TOWN OF DEATH HAVRE de GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVRE de GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 656 OTSEGO STREET 21078		
14. FATHER'S NAME FIRST EARL			MIDDLE			LAST SHARON			15. MOTHER'S MAIDEN NAME FIRST DOROTHY			MIDDLE LAST KELLUM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 527 38 9777			17. INFORMANT MRS DELMA I. BALDWIN			ADDRESS 601 CHAPEL ROAD HAVRE de GRACE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Cardiopulmonary Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Colon widespread metastasis												2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COPD														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1983, to 8-27, 1983, that (I) (we) last saw the deceased alive on 8-26-83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8-27-83		
22b. SIGNATURE Howlett Jackson			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson			22e. ADDRESS 1315. Union Ave Havre De Grace MD 21078											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 30AUGUST83			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD.					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			ADDRESS			25a. DATE REC'D. BY REGISTRAR, REGISTRAR'S SIGNATURE AUG 30 1983 Young, Barbara								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

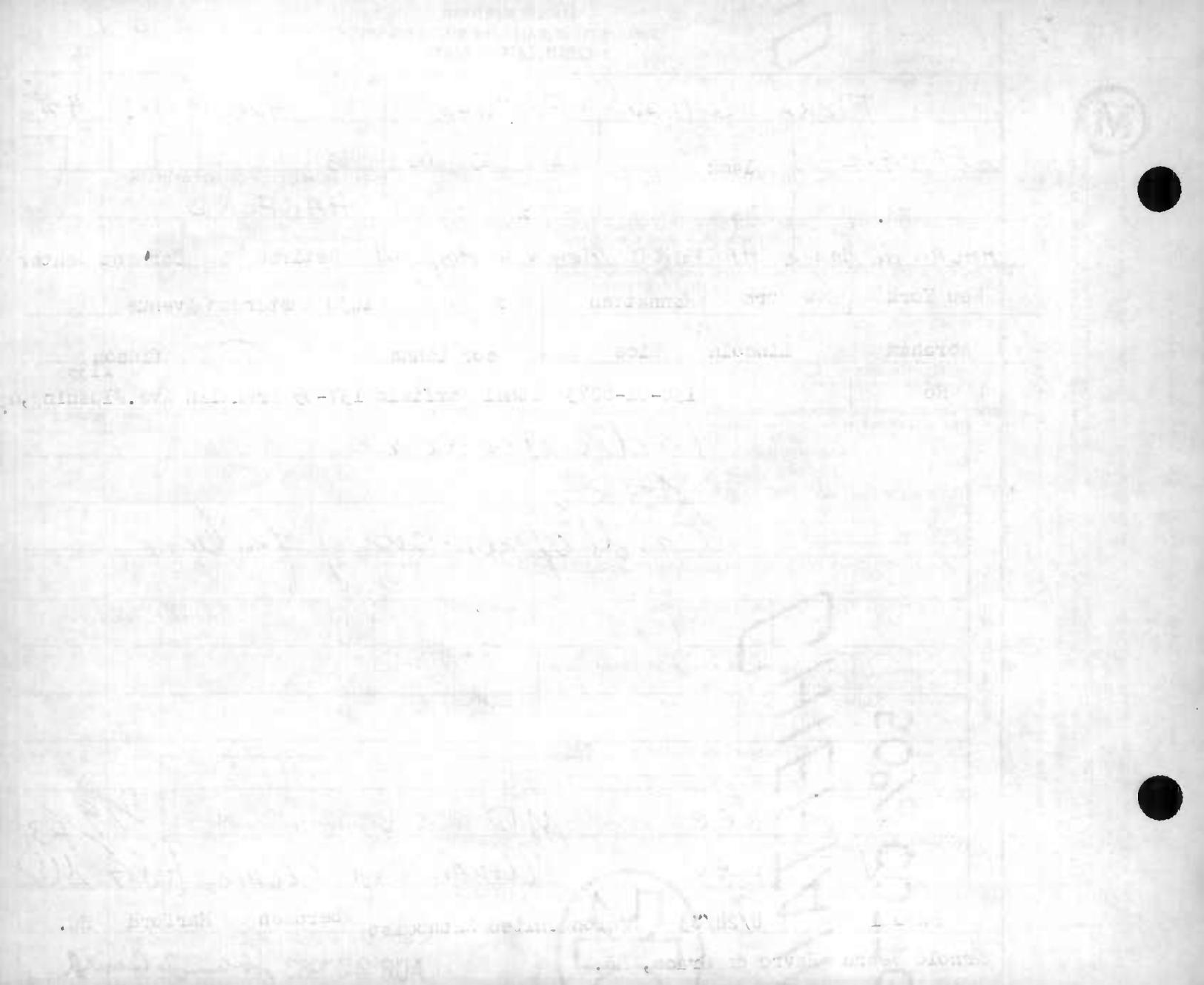
by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 shows any injury or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 21887			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
FLORA Lillian Footman						Aug. 19, 1983			4:15 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			
Female		Black		1 13 00			83			IF UNDER 24 HRS MONTHS DAYS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.						
10 CITY OR TOWN OF DEATH Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY						
HAURE de Grace		HARFORD Memorial Hospital		Retired			Garment Center						
13a. STATE New York		13b. COUNTY New York		13c. CITY OR TOWN Manhattan			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1430 Amsterdam Avenue			
14. FATHER'S NAME FIRST Abraham		MIDDLE Lincoln		LAST Rice			15. MOTHER'S MAIDEN NAME FIRST Georgianna			MIDDLE LAST Tinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 130-01-8273		17. INFORMANT Ethel Warfield			ADDRESS 11355			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) & (c)) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <i>Lactic acidosis</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>As copd</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiopulmonary failure</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J.T. Lee</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8/19/83						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.T. Lee</i>		22f. ADDRESS Union Med Clinic Adm. MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/83		23c. NAME OF CEMETERY OR CREMATORIAL Union United Methodist			23d. LOCATION CITY OR TOWN Aberdeen		COUNTY Harford		STATE Md.		
24. FUNERAL DIRECTOR Arnold Beard Havrd de Grace, Md.		25a. DATE REC'D. BY REGISTRAR AUG 23 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>									
DHMH - 16 50M 4/82 (VRA 15-4)													

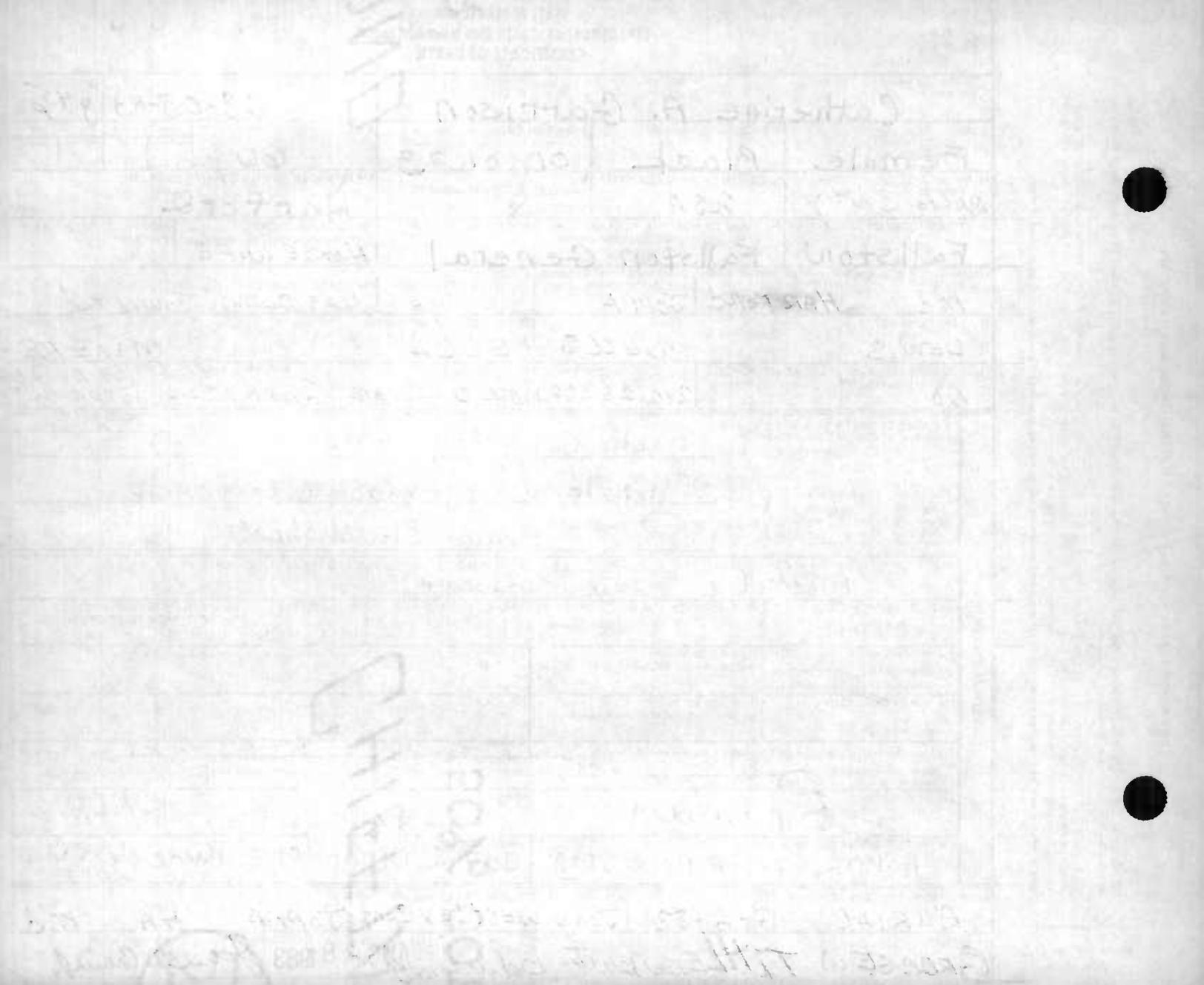


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 21888		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
Catherine A. Garrison						08-03-83						847 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Black			01 01 23			60			YRS.		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
BACTO Entry			USA						Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Fallston			Fallston General			HOUSEWIFE								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Md			Harford			JOPPA			YES			423 Demby Town Rd		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
LEWIS			WELLS			ELLA						MVERRS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			212 263020			MR WILLIAM GARRISON			425 Demby Town					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory failure</i>														
1550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Hepatoma & Metastatic liver disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hepatic Encephalopathy</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Alcoholic liver disease</i>														
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-15-1983 to 8-3-1983, that (I) (we) last saw the deceased alive on 8-3-1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													22c. DATE SIGNED 8/4/83	
22b. SIGNATURE <i>ASHOK HARANE, MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASHOK HARANE, MD			22e. ADDRESS 307 S. UNION AVE. House de Grace MD 21019											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-6-83			23c. NAME OF CEMETERY OR CREMATORIAL John WESTLEY Cemetery			23d. LOCATION CITY OR TOWN JOPPA			COUNTY HA	STATE MD	
24. FUNERAL DIRECTOR NAME GEORGE W. TITTLE			ADDRESS 130 Battie, Bel Air, Md			25a. DATE REC'D. BY REGISTRAR AUG - 8 1983			25b. REGISTRAR'S SIGNATURE John J. Carroll					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after being filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21859	
1 - FOR STATE REGISTRAR		REG. NO.									
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
JOSEPH LAWSON GILBERT					AUGUST 6, 1983					11:03 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 12, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY				MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1504 BARRETT STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) PRES/OWNER		12b. KIND OF BUSINESS OR INDUSTRY FUEL OIL CO.					
13a. STATE MO		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1504 BARRETT STREET		21078	
14. FATHER'S NAME FIRST A. HERBERT		MIDDLE LAST GILBERT		15. MOTHER'S MAIDEN NAME FIRST MARGARET		MIDDLE		LAST WALSH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 14 3227		17. INFORMANT JOSEPH C. GILBERT		ADDRESS P.O. BOX 66 HAVRE de GRACE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4860</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonitis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Heath</i>		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED <i>8/8/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUNTHER HIRSCH, M.D.		22e. ADDRESS 131 SOUTH UNION AVE. HAVRE de GRACE, MARYLAND 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9 AUG 83		23c. NAME OF CEMETERY OR CREMATORIAL BAKERS CEMETERY		23d. LOCATION CITY OR TOWN ABERFOE, HARFORD, MARYLAND		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME MITCHELL		ADDRESS FUNERAL HOME PA, HAVRE de GRACE, MARYLAND				25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE <i>AUG 10 1983 John J. Daniels</i>					

N



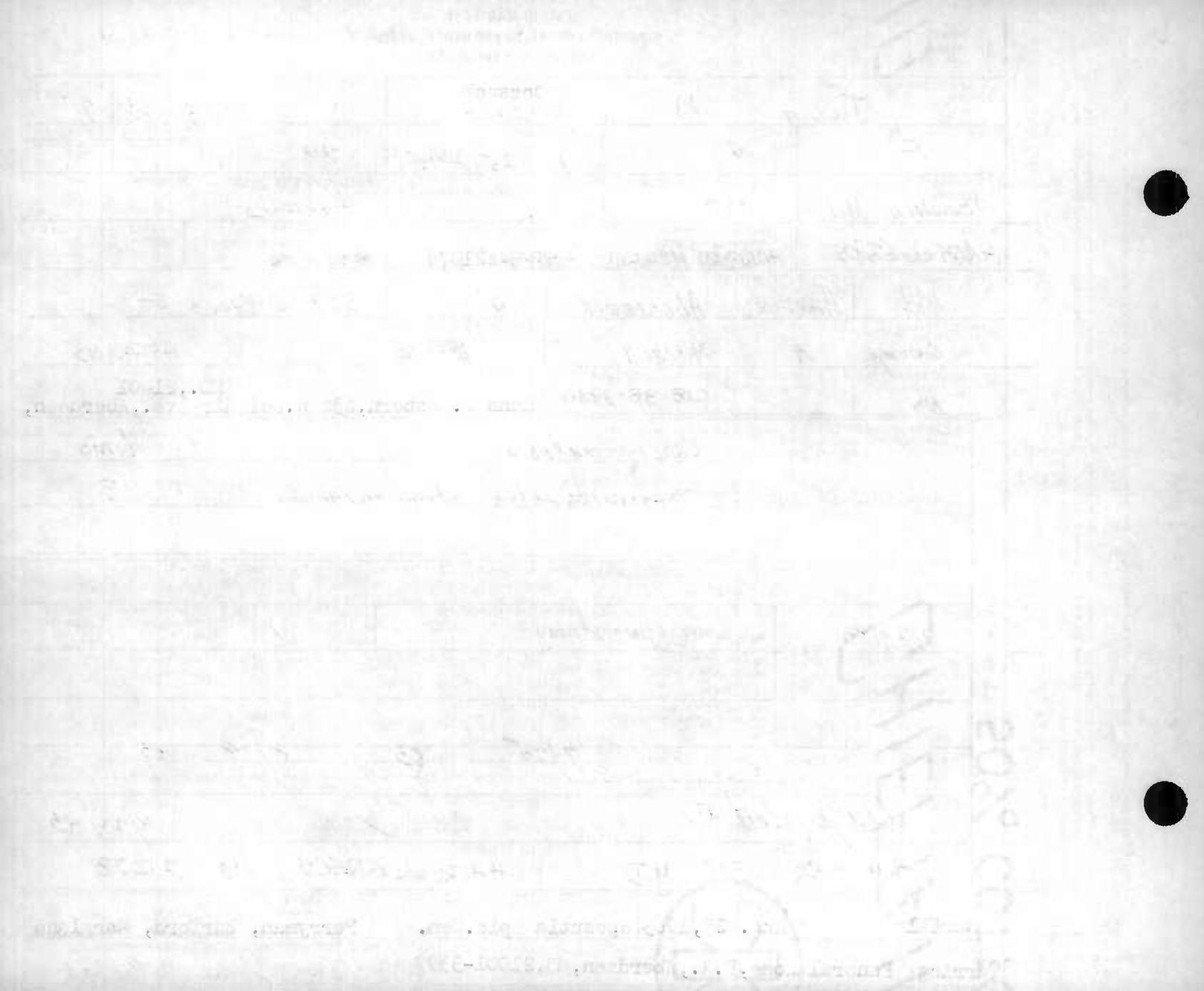
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8321890
1. FOR STATE REGISTRAR					
I. DECEASED NAME (TYPE OR PRINT)		FIRST JULIA	MIDDLE M	LAST Gorsuch	2a. DATE OF DEATH 8-18-83
3. SEX F		4. RACE W	5. DATE OF BIRTH MONTH 1 DAY 25 YEAR 1895		2b. HOUR 7 40 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Aberdeen, Md		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.
10. CITY OR TOWN OF DEATH HARVE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL 21078			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.
13a. STATE Md.		13b. COUNTY HARFORD	13c. CITY OR TOWN ABERDEEN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST George		MIDDLE A	LAST Mitchell	15. MOTHER'S MAIDEN NAME EFFIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-38-3980		17. INFORMANT ADDRESS Edna M. Osborn, 436 W. Bel Air ave., Aberdeen, MD., 21001	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transverse colon adenocarcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1531 9 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ? DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION 7/29/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rejamojejunostomy</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-18-83 to 8-18-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A.W. Grigoleit M.D.</u>		DEGREE		22c. DATE SIGNED 8/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.W. GRIGOLEIT M.D.		22e. ADDRESS HARVE de GRACE, Md 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 23, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Spesutia Epis. Cem.		23d. LOCATION CITY OR TOWN Perryman, Harford, Maryland COUNTY STATE
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 30 1983 John J. Carroll			
DHMH - 16 50M 4/B2 (VRA 15, 4)					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

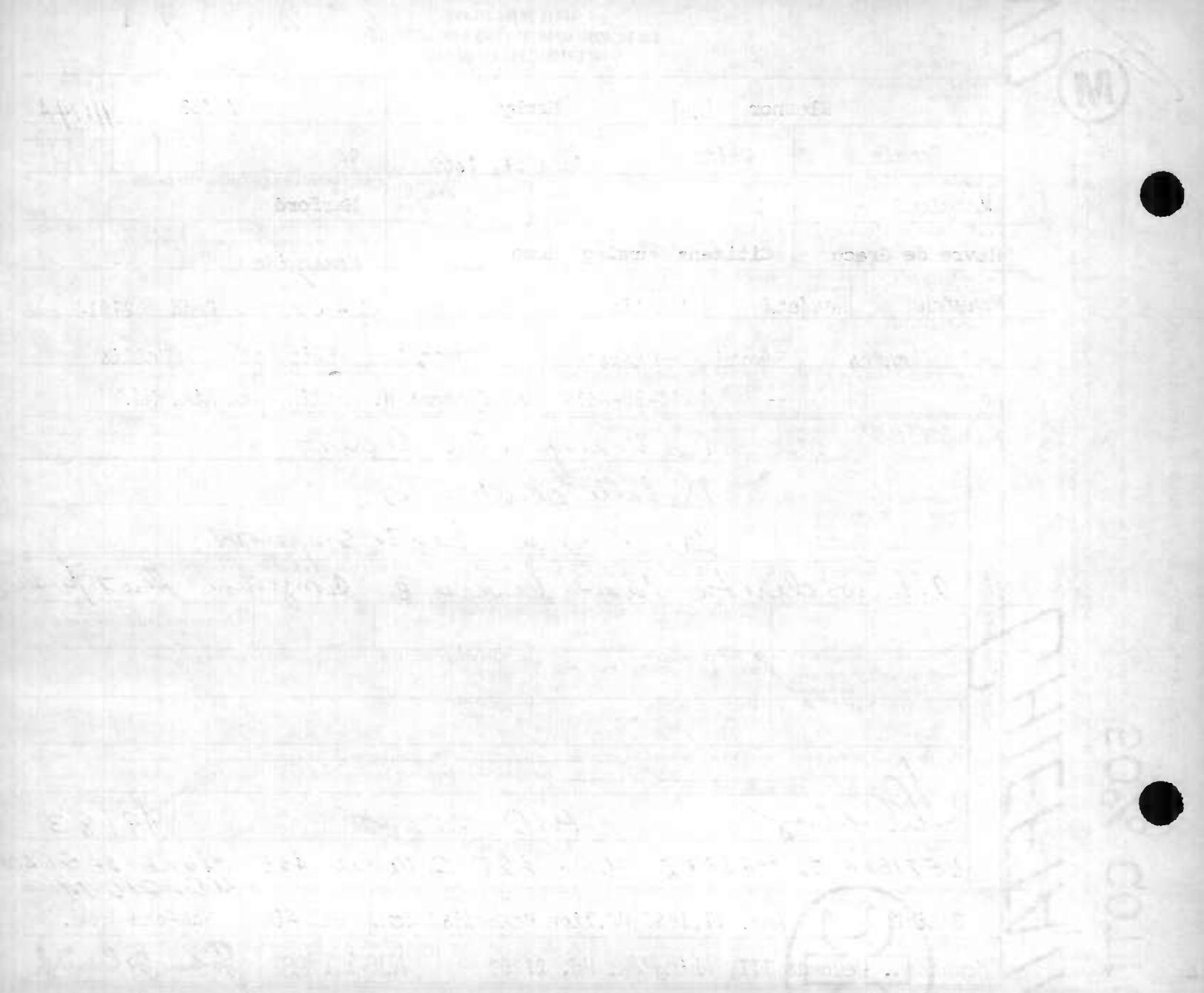
reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 2 1 8 9 1									
												REG. NO.									
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			Eleanor			(mn)			Hamby			8/9/83					11:14 AM				
3. SEX			Female			White			5. DATE OF BIRTH MONTH DAY YEAR			June 21, 1889		6. AGE (IN YEARS LAST BIRTHDAY)		94		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Maryland			7b. CITIZEN OF WHAT COUNTRY?			USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Harford MD.					
10. CITY OR TOWN OF DEATH			Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Citizens Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE			Maryland			13b. COUNTY			Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		2204 Creswell Road 21014					
14. FATHER'S NAME FIRST			Charles			MIDDLE			Edward			15. MOTHER'S MAIDEN NAME FIRST		Hannah		Elizabeth		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			--			17. INFORMANT		Wallis ADDRESS Mrs. Eleanor H. Martin, Bel Air, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cardiorespiratory Arrest									
1540 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DOUE TO, OR AS A CONSEQUENCE OF (b) Probable peritonitis																					
DOUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Recto sigmoid.																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												Arteriosclerotic Thaart Disease & Congestive Heart Failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 99/83									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			LETICIA S. GALVER M.D.			22e. ADDRESS			625 S. UNION AVE HAVRE DE GRACE MD. 21078												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Methodist Cem.			23d. LOCATION CITY OR TOWN			COUNTY			STATE			
24. FUNERAL DIRECTOR NAME			Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
									AUG 11 1983												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

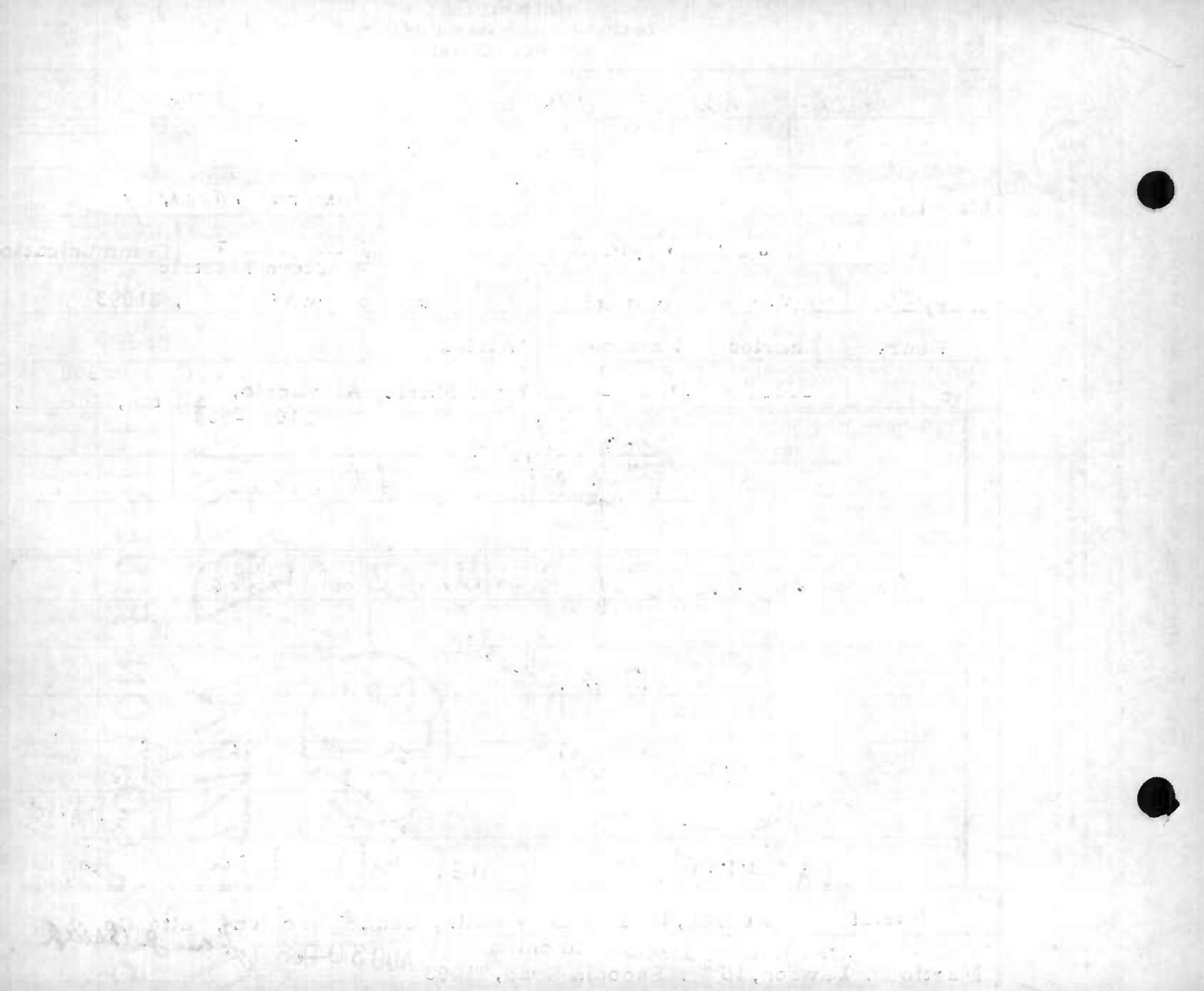
IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 21892		
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE A. S.	LAST Hammond	2a. DATE OF DEATH Aug 27 1983			MONTH	DAY	YEAR	2b. HOUR 9 52 P.M.
3. SEX Male			4. RACE White			5. DATE OF BIRTH Sept. 3, 1893			MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist			12b. KIND OF BUSINESS OR INDUSTRY Chemicals			
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 200 Timber Trail, Apt. D
14. FATHER'S NAME FIRST James			MIDDLE Neuburn	LAST Hammond	15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE Faithful	LAST Hickman	ADDRESS White Hall, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 043-03-1343			17. INFORMANT Emma L. Taylor			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA. 1850 DUE TO, OR AS A CONSEQUENCE OF Prostate - CA.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8-14, 1983, to 8-27, 1983, that (I) (we) last saw the deceased alive on 8-27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. Parekh			22c. DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 8/28/83.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Parekh			22e. ADDRESS 1908 Harford Rd, Fallston MD 21047									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/29/1983			23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Baltimore, Md.			
24 FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.			25a. DATE REC'D. BY REGISTRAR AUG 30 1983			25b. REGISTRAR'S SIGNATURE John J. Smith			
BP _____												
DHMH - 16 50M 4/82 (VRA 15, 4)												

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21893							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
GEORGE AUGUST HARMONY						8-26-83			10:00A M								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		Sept. 8, 1906			76			MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		USA					Harford County,										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Fallston		Fallston General Hospital		Millwright -			Western Electric										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Baltimore		Timonium						4 Gorsuch Road, 21093							
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			ADDRESS				
Henry Charles Harmony				Alvina			No			Mrs. Shirley A. Facelo,			P. O. Box 308				
16b. SOCIAL SECURITY NO.		16c. ADDRESS			17d. LAST NAME			21047-0308			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
214-03-7707																	
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II.) PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>7070</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ciliulitis scatul area</i>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.																	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alvined Cancer of prostate, Renal Failure</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET						CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/83</i> , 19 <i>83</i> , to <i>8/26/83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>8/26/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Martin D. Lawson</i>										22c. DEGREE							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Martin D. Lawson, Jr.</i>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE <i>Aug. 29, 1983</i>				23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Cem. Timonium			
23d. LOCATION CITY OR TOWN										23e. COUNTY STATE							
Burial										Balto. Co. MD.							
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR <i>AUG 30 1983</i>							
Martin D. Lawson, 10 W. Padonia Road, 21093										25b. REC'D. BY CLERK <i>John C. Smith</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8-3 21894			
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			
CLARENCE OLIVER HAWKINS			12 10 24			8-3-83			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR 1:50 P.M.			
M	B	12 10 24	58 YRS.						
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD	
Md.		USA						MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self employed			12b. KIND OF BUSINESS OR INDUSTRY cement finisher	
13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 166 E. Dean St.	21005	
14. FATHER'S NAME FIRST Ralph		MIDDLE	LAST Hawkins	15. MOTHER'S MAIDEN NAME FIRST Ella			MIDDLE Mae	LAST Maddox	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-14-1259			17. INFORMANT Marie Ballard 166 E. Dean St.			Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypercalcemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the stomach metastasis</u> several months									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Atherosclerotic heart disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-20-83, 19, to 8-3-83, 19, that (I) (we) last saw the deceased alive on 8-3-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) / (did not) view the body after death.									
22b. SIGNATURE <u>Howlett Jackson</u>									22c. DEGREE M.D.
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howlett Jackson</u>									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									22e. ADDRESS 1315 Union Ave Havre De Grace Md. 21078
23b. DATE 8/8/83									23d. LOCATION CITY OR TOWN Darlington
23c. NAME OF CEMETERY OR CREMATORIAL Berkley Cemetery									COUNTY Harford
24. FUNERAL DIRECTOR Arnold Beard Havre de Grace, Md.									STATE Md.
25a. DATE REC'D. BY REGISTRAR AUG 9 1983									25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>
BP _____									
DHMH - 16 50M 4/82 (VRA 15, 4)									

Montgomery, Alabama

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Montgomery, Alabama

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Montgomery, Alabama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21395					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			August 11, 83				3:27 P.M.					
Claude CLINTON Herring															
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
M			W			3 24 04			79 YRS.						
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
VA			U.S.						Harford						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston			Fallston General Hospital			Pipefitter			Steel						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Harford			Edgewood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2207 Snow Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Claude			Middle Thomas			Last Herring			First Cornelia			Middle --			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			213-07-5486			Mrs. Ellie M. Herring, 2207 Snow Road			Edgewood, Md. 21040						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest,</u> <u>4273</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3:27 pm</u>					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Cerebral vascular Disease</u>										<u>year</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>atrial fibrillation history 8 TIA's</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b <u>Diabetes</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1983</u> , to <u>May 11, 1983</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE <u>Albert Sun, M.D.</u>										DEGREE			22c. DATE SIGNED <u>8/11/83</u>		
ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert Sun, M.D.</u>			22e. ADDRESS <u>1800 Harford Rd. Fallston 21047</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 13, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air Harford Md.			24a. LOCATION CITY OR TOWN COUNTY STATE						
24 FUNERAL DIRECTOR NAME <u>Howard K. McComas III, Abingdon, Md. 21009</u>			ADDRESS						25a. DATE REC'D. BY REGISTRAR <u>AUG 15 1983</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Comish</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from us or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 02 05 14	83 21896				
1 - FOR STATE REGISTRAR			FIRST MARY			MIDDLE Jeanette			LAST H. bbs			2a. DATE OF DEATH 08 25 83	MONTH YEAR	DAY	YEAR	2b. HOUR 35 5 AM M	
1. DECEASED NAME (TYPE OR PRINT)																	
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH MONTH 06			YEAR 14			6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Harford			IF UNDER 24 MRS MONTHS HOURS MIN.		
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			MD. 21040					
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 474 Sedgemore Court					
14. FATHER'S NAME FIRST Robert			MIDDLE Walters			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Lou			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-22-7086			17. INFORMANT Henry Lee Hibbs			ADDRESS same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Advanced Cancer of Pancreas</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year					
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cathexis, Drabets Melitus & + Pancreatic C</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MON DAY P.M. 19			21c. INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>Abdominal</i>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>8/23</i>			21f. LOCATION STREET <i>8/23</i>			CITY OR TOWN <i>8/23</i>			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/23</i> , 19 <i>83</i> , to <i>8/25/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>8/25/83</i>					
22b. SIGNATURE <i>Mary</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>UZAZIN, M.</i>			22e. ADDRESS <i>1131 Bel Air Rd Bel Air Md</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8/29/83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Mem. Gardens</i>			23d. LOCATION CITY OR TOWN <i>Bel Air</i>		
24. FUNERAL DIRECTOR NAME <i>Arnold W. Beard</i>			ADDRESS <i>353 Fountain St</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 30 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John & Conie</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	21891		
										REG. NO.			
1. FOR STATE REGISTRAR			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			5. DATE OF BIRTH			MONTH	DAY	YEAR	9:15 PM	
William V. Hedges						5 18 01							
3. SEX			4. RACE			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Caucasian			82			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA						Harford Co. MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bel Air			Bel Air Convalescent Center			Electrician			Martins				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21047	
Maryland			Harford						1718 Laurel Brook Rd.				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			Pierce	
William			Hedges			Mary						(21047)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			214 01 3151			Hazel B. Hodes			1718 Laurel Brook Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140</u> DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DOUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular Arrest</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> to <u>8/3</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>MANUEL</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/3/83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MANUEL</u>			22e. ADDRESS 8 Law St, Aberdeen MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-3-83			23c. NAME OF FACTORY OR CEMETERY Westview Mem. New Cathedra			23d. LOCATION CITY OR TOWN Pk. Cem. Balto., Md.				
24. FUNERAL DIRECTOR NAME E. F. Lassahn Fun. H.			11750 Belair Rd. ADDRESS Kingsville, Md.			25a. DATE REC'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Coughlin</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical certification must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 1 8 9 8		
										REG. NO.		
1. DECEASED NAME FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
FLORENCE VIRGINIA Holly										8 26 83	4:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH [*]			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Female		Caucasian		MONTH	DAY	YEAR	93	IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Virginia		USA					HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Bel Air		Bel Air CONVALESCENT CTR		Clerk BALTO.			TRANSIT			21059		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21059	
Md.		BALTO.		Glen Arm					11967 HARFORD Rd.			
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		NORTHAM	
ARTIMUS				MARY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		214-22-0259		BEL AIR CONVALESCENT CTR								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Congestive Heart failure												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis												
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture right hip 10.22.82												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				<input type="checkbox"/> YES <input type="checkbox"/> NO		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from Nov 82 to Jan 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		19 82 to 19 83										
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		
William A. Tyson												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED								
William A. Tyson		Box 158 Kingsville Md.		8-26-83								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION		23d. LOCATION OF OWN		23e. COUNTY		23f. STATE		
Burial		8-30-83		MORELAND MEM. PARK		Balto		Md.				
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
EVANS CHAPEL OF MEMORIES 8800 Harford Rd		AUG 31 1983		John G. Canfield								

BOOK BENCH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 1 8 9 9				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Mary (NHN)					Hughes	August 1 1983						6 35 p.m.		
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			white	AUG. 13 1907			75			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
MD.			USA						Harford			MONTHS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Harve de Grace			Harford Memorial Hosp			CLERK TYPIST			PERRY POINT V.A. CENTER					
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Harford	Harve de Grace			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			505 Congress Ave 21048				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
GEORGE			WARREN	HUGHES SR	LAURA						ANTHONY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			216-44-4421			ELEANOR P. CARR			WEBSTER 21048					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4360			minutes											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Cerebrovascular Accident											
DUE TO, OR AS A CONSEQUENCE OF			16 days											
(c) Atherosclerosis			years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>83</u> , to <u>August 1</u> , 19 <u>83</u> , that (I) (we) lost sow the deceased alive on <u>August 1</u> , 19 <u>83</u> , old that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Howlett Jackson M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED August 1, 1983					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson			22e. ADDRESS 1315. Union Ave Harve de Grace Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BUBRIAH AUG. 3 1983			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEM. HARVE DE GRACE HARFORD MD			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Micheal F. H. P.A.			ADDRESS HAURE DE GRACE, MD.			25a. DATE REG'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Cahill					

14

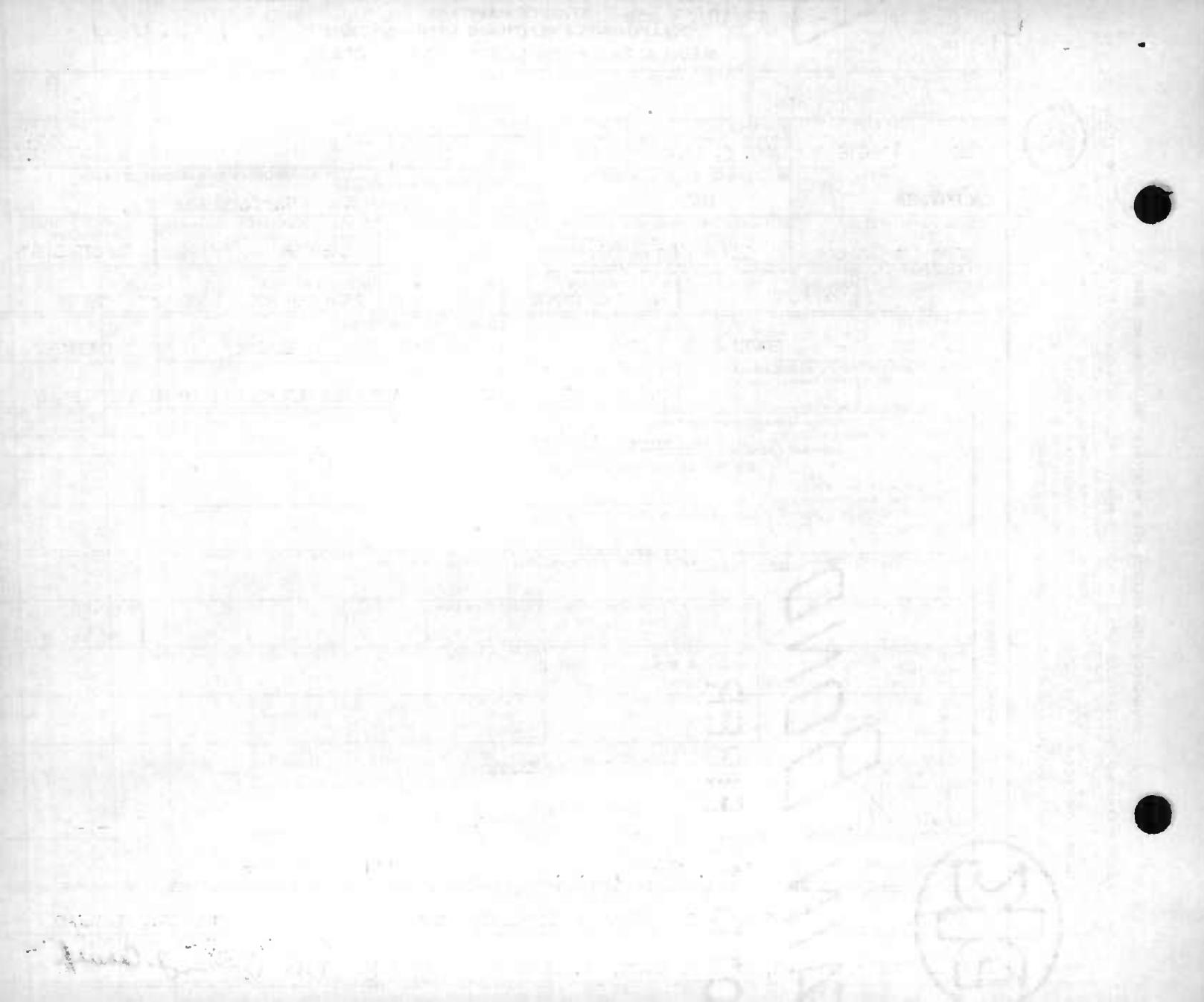
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61 62 63 64
65 66 67 68
69 70 71 72
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G#585 Items 18-22a 11/10/83 mtb STATE OF MARYLAND
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1 - STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21900

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Guthrie			A.	Jones		<input checked="" type="checkbox"/>	8	29	1983	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE	WHITE	AUG. 5, 1954	29 yrs.			9	2	1983	3:00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
CALIFORNIA		USA				Harford County, MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Harve De Grace		2504 Old Robinhood Road			LABORER			CONSTRUCTION		
13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2504 OLD ROBIN HOOD ROAD 21078					
14. FATHER'S NAME FIRST GUTHRIE		MIDDLE EDWIN	LAST JONES	15. MOTHER'S MAIDEN NAME FIRST BEVERLY	MIDDLE ELAINE	LAST CHENNEL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215 58 0923		17. INFORMANT EUGENIA WHYTE 2526 OLD ROBIN HOOD RD ABERDEEN, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7803 IMMEDIATE CAUSE (a) Seizure Disorder Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7 SEPTEMBER 83		23c. NAME OF CEMETERY OR CREMATORIAL WESLEYAN CHAPEL CEMETERY		23d. LOCATION CITY OR TOWN		COUNTY STATE		
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				25a. DATE REC'D. BY REGISTRAR SEP 8 1983		25b. REGISTRAR'S SIGNATURE <i>John C. Carroll</i>				



10 21901

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO.											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
WILLIAM DAVID KEGLEY						12	23	1912	8	24	83
3. SEX			4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7b. HOUR					
Male			White	MONTH DAY YEAR	70	10:05 A			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			USA						HARFORD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
HARFORD			HARFORD MEMORIAL HOSPITAL			Retired					
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Md.			HARFORD	HARFORD	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1224 CHESAPEAKE DRIVE, 21078					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
William			M.	Kegley	Maggie	Corbitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			236-07-1760			Anna Lee Kegley, 1224 Chesapeake Drive,			HARFORD, Md. 21078		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):											
1629 Rheumatism & Organ failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO OR AS A CONSEQUENCE OF (b) Metastatic ca. Carcinomatosis, liver & Bone											
DUE TO OR AS A CONSEQUENCE OF (c) most likely - Lung CA, primary											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Lung & heart disease problem & bleeding - Sepsis											
19. MEDICAL CERTIFICATION DATE OF OPERATION:			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
None						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
NO			8-6 1983			able					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (HOSPITAL, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
			A								
22a. I certify that (I) (this hospital) attended the deceased from 8-6 1983 to 8-24 1983, that (I) (we) last saw the deceased alive on 8-24 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Cecilia T. Camacho, M.D.									8-24-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
CECILIA T. CAMACHO			1013 Edgewood Edgewood Rd. 21040								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial			08/27/83			Harford Mem. Gardens			Aberdeen, R.D., Harford Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399									AUG 29 1983		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

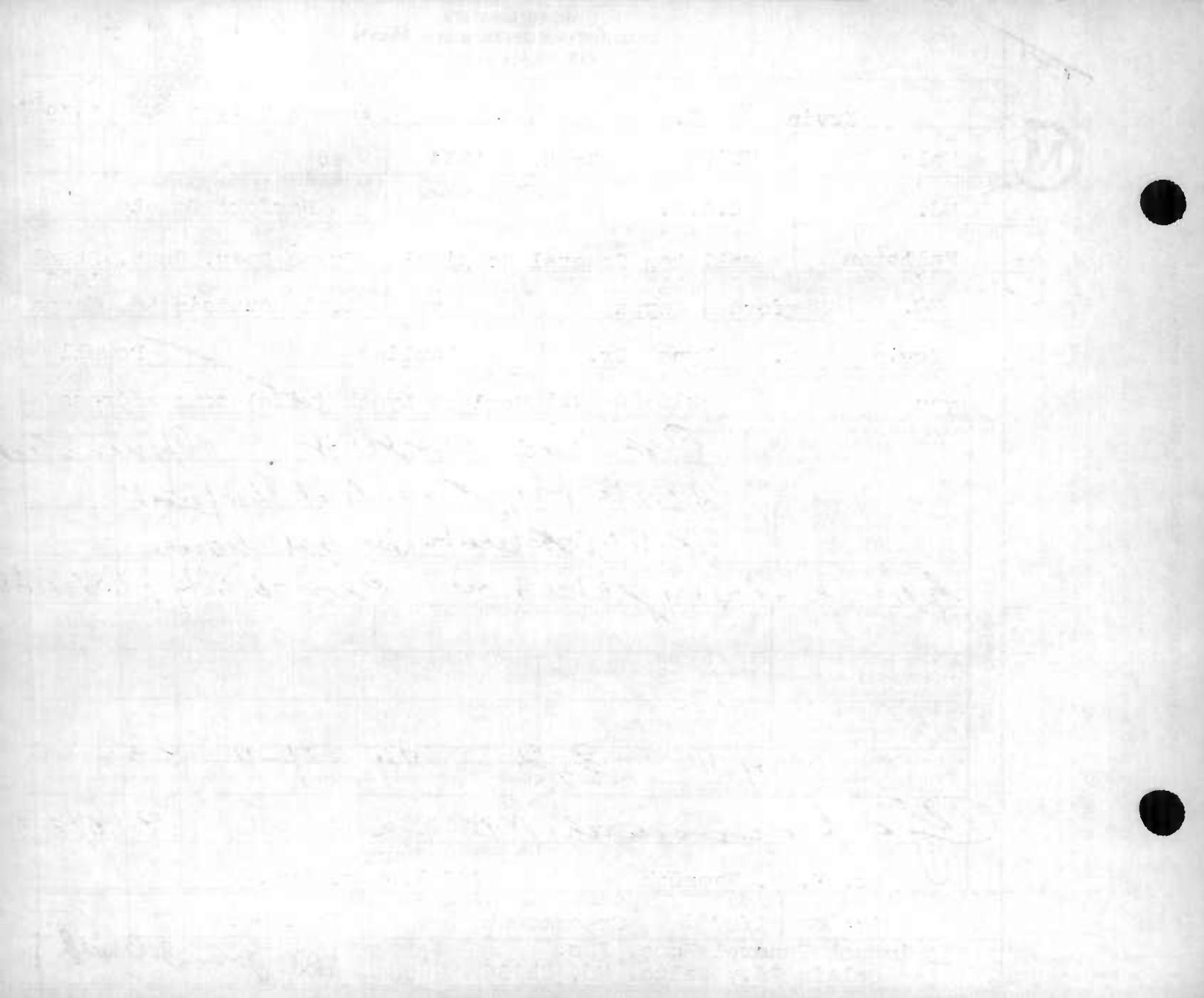
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 83

2 1 9 0 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Irvin B. Lynch						August 7 1983				1:49 A.M.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White	Sept. 2 1934			48			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.						Harford County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		Fallston General Hospital			Crane Oper.			Beth. Steel					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21085			
Md.		Harford		Joppa				1821 Mountain Rd. Joppa					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	21085			
		Irvin	B.	Lynch Sr.			Pauline		Powell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS						
yes		215-30-4223			Marlene Lynch (wife)		same address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute myocardial infarct</i> (c) <i>Postischemic heart disease</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Hyperthyroidism</i> <i>also obesity, chb, coronary</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 19 <u>83</u> to <u>7-11</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>7-1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Dr. Y. K. Ramaiah</i>		MD			DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED <i>8/8/83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Dr. Y. K. Ramaiah			22e. ADDRESS		North 447 Kenwood Ave.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Cremation		8/9/83		Greenmount		Baltimore		Md.			<i>John J. Linnell</i>		
24. FUNERAL DIRECTOR SC Grindeneck Funeral Home, Inc.		ADDRESS 9705 Belair Rd., Balto. Md. 21236			AUG 9 1983								
BP													
DHMH - 16 50M 4/83 (VRA 15, 4)													



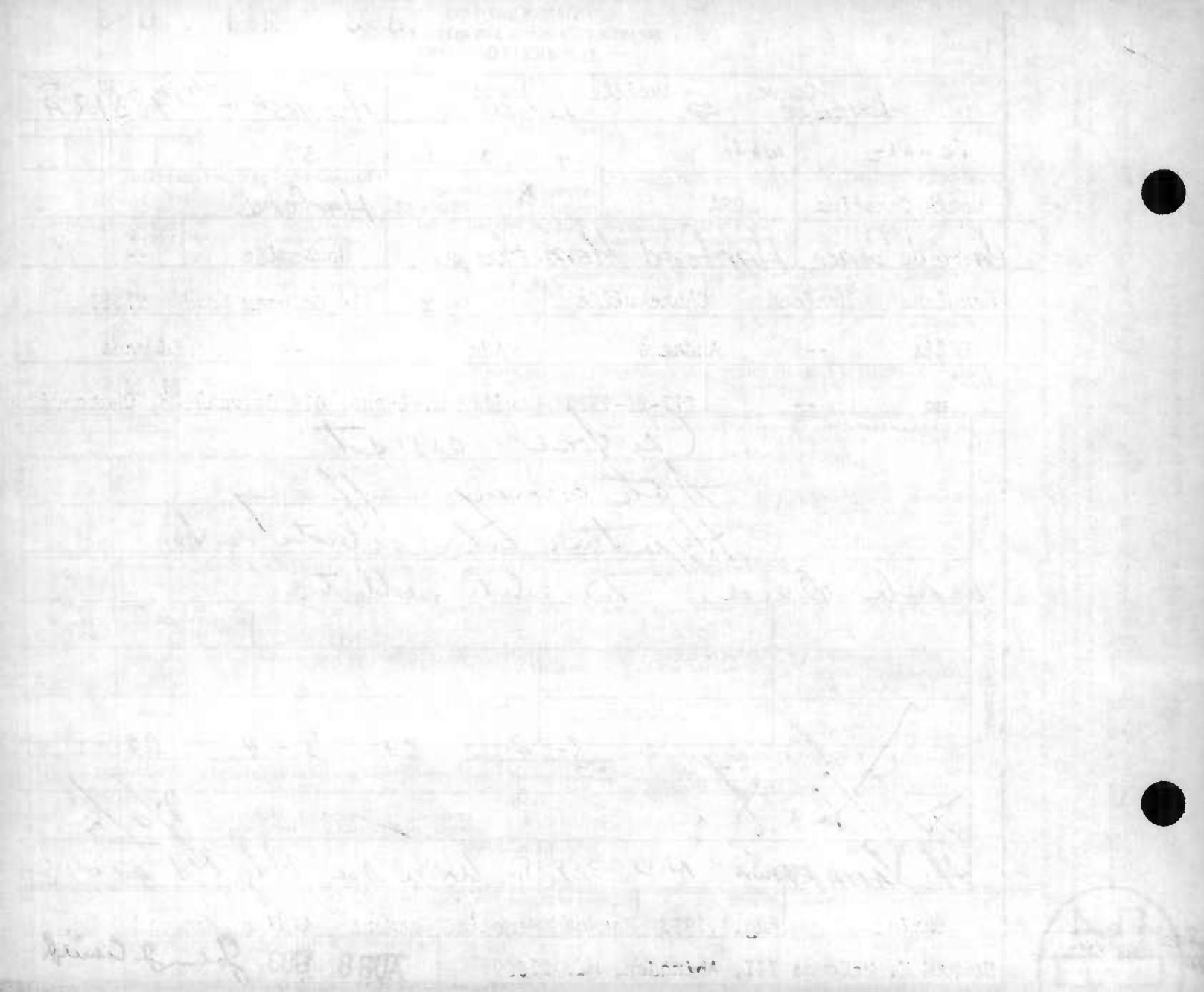
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8321903	
										REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Lucille</i>	MIDDLE <i>Lucille</i>	LAST <i>Lyons</i>	2b. DATE OF DEATH			MONTH <i>Aug</i>	DAY <i>4</i>	YEAR <i>1983</i>	2b. HOUR <i>12A M</i>
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		white		MONTH <i>4</i>	DAY <i>13</i>	YEAR <i>24</i>	59 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
North Carolina		USA					Hartford				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12b. KIND OF BUSINESS OR INDUSTRY	
10b. <i>Sainte de Grace</i>		<i>Hartford Mem. Hosp.</i>								--	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Hartford</i>		13c. CITY OR TOWN <i>churchville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>614 Calvary Road</i>		21028	
14. FATHER'S NAME FIRST <i>Ellis</i>		MIDDLE <i>--</i>	LAST <i>Andrews</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ada</i>		MIDDLE <i>--</i>	LAST <i>Edwards</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>no --</i>		17. INFORMANT <i>Orville H. Lyons, 614 Calvary Rd, Churchville</i>		ADDRESS <i>Md. 21028</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and item (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car bone arrest</i>											
DUE TO OR AS A CONSEQUENCE OF (b) <i>Hart coronary suffusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive arterosclerotic cardio-</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Vascular Disease, Diabetes mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>8-4 1983</i> to <i>8-4 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>John J. Lyons</i>		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>8/4/83</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Lyons</i>		22f. ADDRESS <i>50. W. or St. Hg Md. 21028</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 6, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		23d. LOCATION CITY OR TOWN <i>Aldine</i>		23e. COUNTY <i>Hartford</i>		23f. STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i>		ADDRESS <i>Abingdon, Md. 21009</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Lyons</i>					



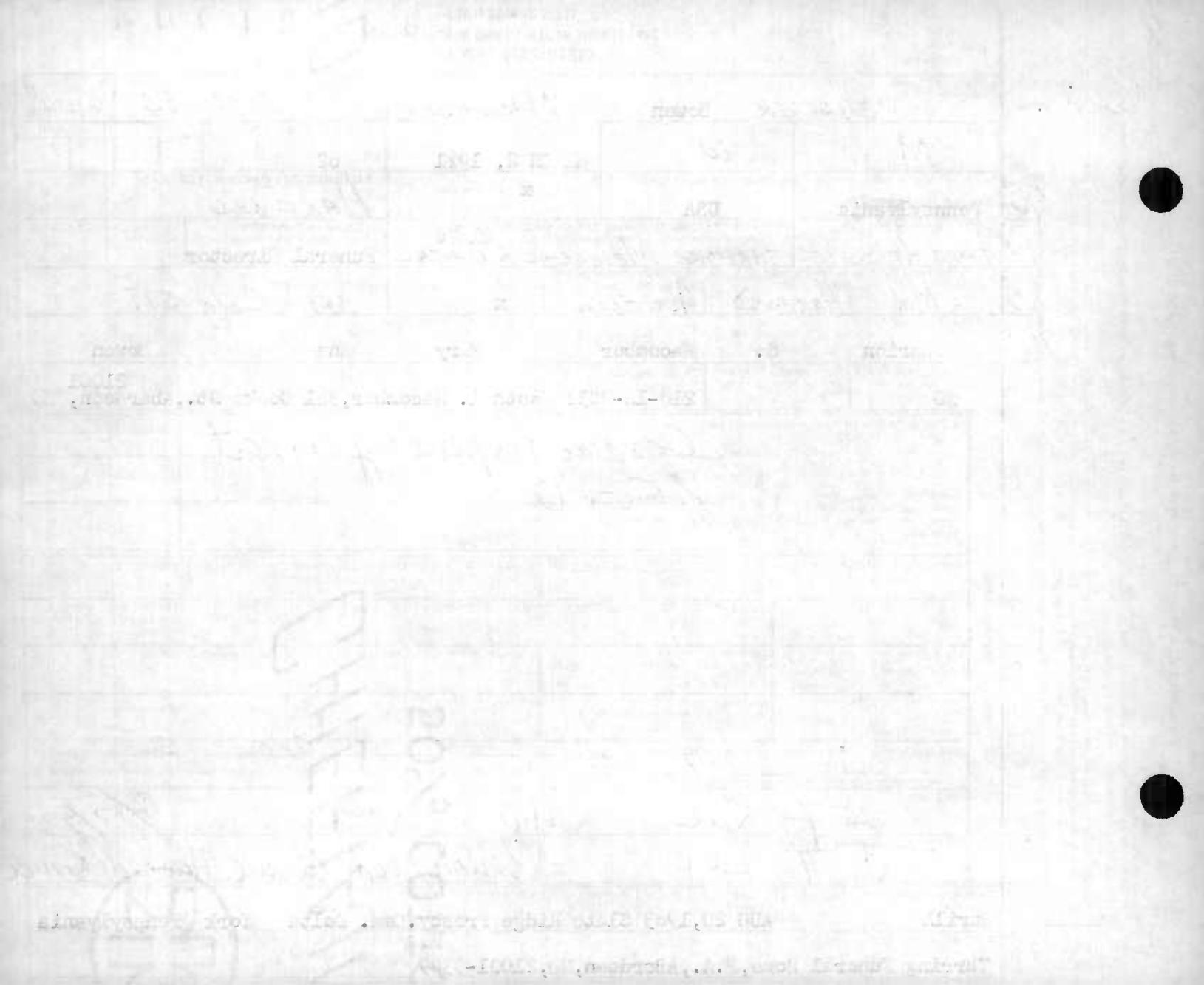
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 1 9 0 4								
												REG. NO.								
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST WEBSTER			MIDDLE Bowen			LAST Macomber			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
M			4 RACE W			5. DATE OF BIRTH MONTH DAY YEAR			MARCH 2, 1921			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			MD.					
10. CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			21078			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Funeral Director			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md			13b. COUNTY HARFORD			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 341 Cooke St.			21001					
14. FATHER'S NAME FIRST Marion			MIDDLE S.			LAST Macomber			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Ann			LAST Bowen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-0832			17. INFORMANT			ADDRESS Ruth A. Macomber, 341 Cooke St., Aberdeen, MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest</u>																				
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ASCOID</u> (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8-11 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															21g. DATE SIGNED 8-11-83					
22b. SIGNATURE <u>J. Lee.</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Burial			22e. ADDRESS Union Med. Clinic. Havre de Grace			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE AUG 20, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge Presby.Cem. Delta York Pennsylvania			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR AUG 23 1983			25b. REGISTRAR'S SIGNATURE J. Lee.														



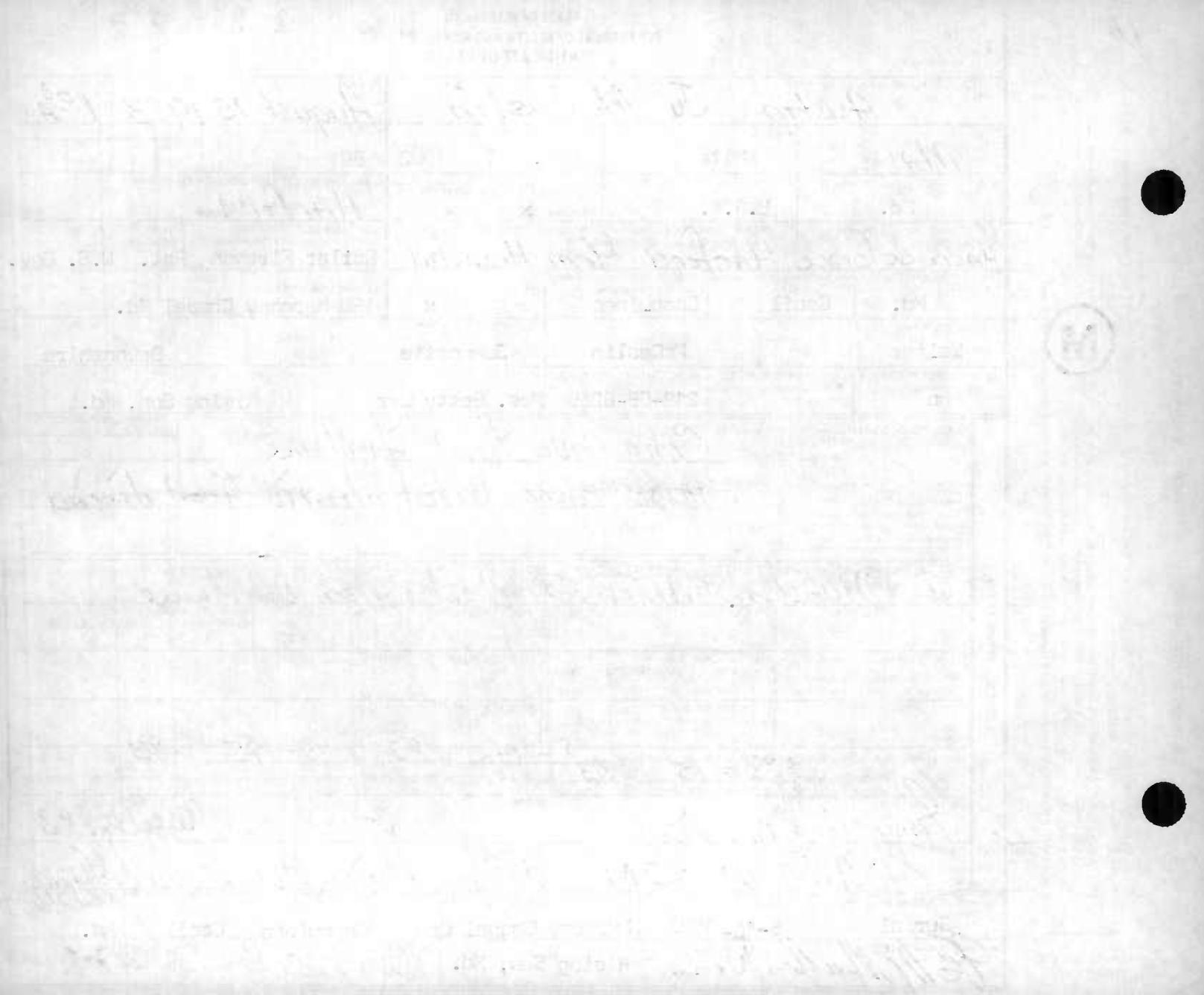
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the hospital or attending physician, it should be detached for use as the burial permit. Then please remove carbon paper. Page 4 may be retained by the funeral director; page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21905				
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Austin Tu McCaslin								August 15, 1983				1983	1:30 P.M.	
35			1. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH NOV. DAY 1902		YEAR	6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford		MD.				
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Fireman		12b. KIND OF BUSINESS OR INDUSTRY Ret. U.S. Gov.						
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Conowingo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 160 Harmony Chapel Rd.		21918		
14. FATHER'S NAME Walter			15. MOTHER'S MAIDEN NAME McCaslin			16. SOCIAL SECURITY NO. 218-09-6269		17. INFORMANT Mrs. Betty Orr		ADDRESS Rising Sun, Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-09-6269			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029			18. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic heart disease			18. DUE TO, OR AS A CONSEQUENCE OF (c)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). ① Diabetes mellitus ② Hypertension ③ Arteriosclerotic heart disease														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-14 1983 to 8-15 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Sang W. Kim, M.D.			22c. DEGREE			22d. ATTENDING PHYSICIAN PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED Aug. 15, 1983						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM			22f. ADDRESS 308 S. Union Ave. Havre de Grace											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-16-1983			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Chapel Cem.		23d. LOCATION CITY OR TOWN Conowingo		COUNTY	STATE Cecil Md.			
24. FUNERAL DIRECTOR NAME John Allen Davis			25a. ADDRESS Rising Sun, Md.			25b. DATE REC'D. BY REGISTRAR AUG 19 1983		25c. REGISTRAR'S SIGNATURE John J. Conard						

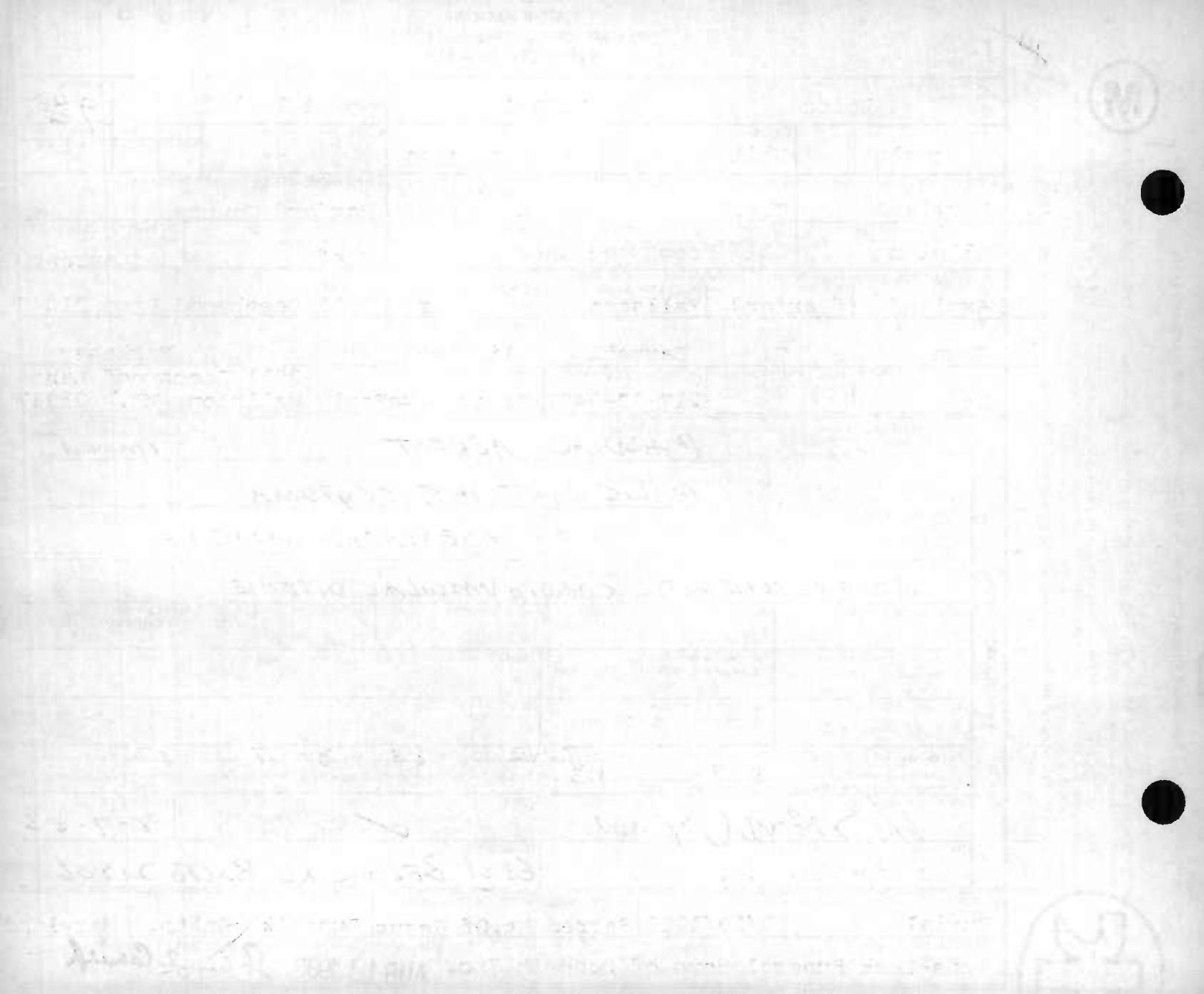


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21906			
												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Helen			McFaule			August 7, 1983			9:40 AM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Female			White			1 1 1911			72 YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			U.S.A.						Harford County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>If more than one facility, give street address</small>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston			2811 Beechwood Lane			Chef			Restaurant						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Harford			Fallston						2811 Beechwood Lane 21047			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
John T. Barrett			Elizabeth Mackessy			NO			217-12-5487			James M. McFaule			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed.									
1719			MALIGANT HISTIOCYTOMA												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(c) WITH WIDE SPREAD METASTASES												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 83, to 8-7 19 83, that (I) (we) last saw the deceased alive on 8-7-19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Bo Zaw-Win, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8-7-83						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			6801 BELAIR RD BALTO 21206									
Bo Zaw-Win, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			8/10/1983			Sacred Ht. Of Jesus			Dundalk Balto. Maryland						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Duda-Ruck Funeral Home of Dundalk, Inc.									AUG 11 1983			John J. Conner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21901

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 12 AM
Albertha	M	MEETINGS		8 21 83	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White	12/23/04	87 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH	Md.	
Maryland	United States		Holmes County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Hause DeGrace	Brevier Nursing Home	Housewife	Home		
13e. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER		
Maryland	Cecil	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	41 Courts Drive Bay County Estates		
14. FATHER'S NAME	First	Middle	Last	Middle	Last
Philip	S	Hines	Albertha	MAY	Lilley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
Unknown	219-07-5648	Mrs Faye Sawyer RT 2 Northeast, Md 21901			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 3 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arthritis, Senile Dementia</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3-28, 1982, to 8-21, 1983, that (I) (we) last saw the deceased alive on 7-30 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Howell Jackson</u>	M.D.	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Aug. 21, 1983
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8-24-83	23c. NAME OF CEMETERY OR CREMATORIUM North East Meth. Cem.	23d. LOCATION (City or Town) (County) North East Cecil Md.	(State)	
24. FUNERAL DIRECTOR Crouch Funeral Home	ADDRESS North East, Md.	25a. REC'D BY REGISTRAR DATE AUG 24 1983	25b. REGISTRAR'S SIGNATURE <u>James Crouch</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND 8 3 2 1 9 8 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				
REG. NO. _____				
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>Jessie</i>	MIDDLE <i>A.</i>	LAST <i>miller</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>8 7 83</i>
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 15 06</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>77</i>	7b. HOUR <i>3:00 AM</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Citizens Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>
13a. STATE <i>Md.</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Havre DeGrace</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>816 Garfield Road</i>
14. FATHER'S NAME FIRST <i>Jack</i>	MIDDLE <i>Jones</i>	LAST <i>Jones</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Jessie</i>	MIDDLE <i>Jones</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>217-18-9850</i>	17. INFORMANT <i>Ernest O. Jones</i>	ADDRESS <i>Same as above</i>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4360</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>				
DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes Mellitus ; bilateral Amputee</i>				
19a. DATE OF OPERATION <i>9/9</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTO/SYP? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET <i>625 S. UNION AVE.</i>	CITY OR TOWN <i>HAVRE DE GRACE</i>	COUNTY <i>Cecil</i>
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				
22b. SIGNATURE <i>Leticia S. Galvez</i> DEGREE <i>M.D.</i> ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				
22c. ADDRESS <i>625 S. UNION AVE. HAVRE DE GRACE</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>8/11/83</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zoar Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Conowingo</i>	COUNTY <i>Cecil</i>
24. FUNERAL DIRECTOR <i>Arnold Beard Havre de Grace, Md.</i>				
25a. DATE REC'D. BY REGISTRAR <i>AUG 9 1983</i> 25b. REGISTRAR'S SIGNATURE <i>John J. Conwell</i>				

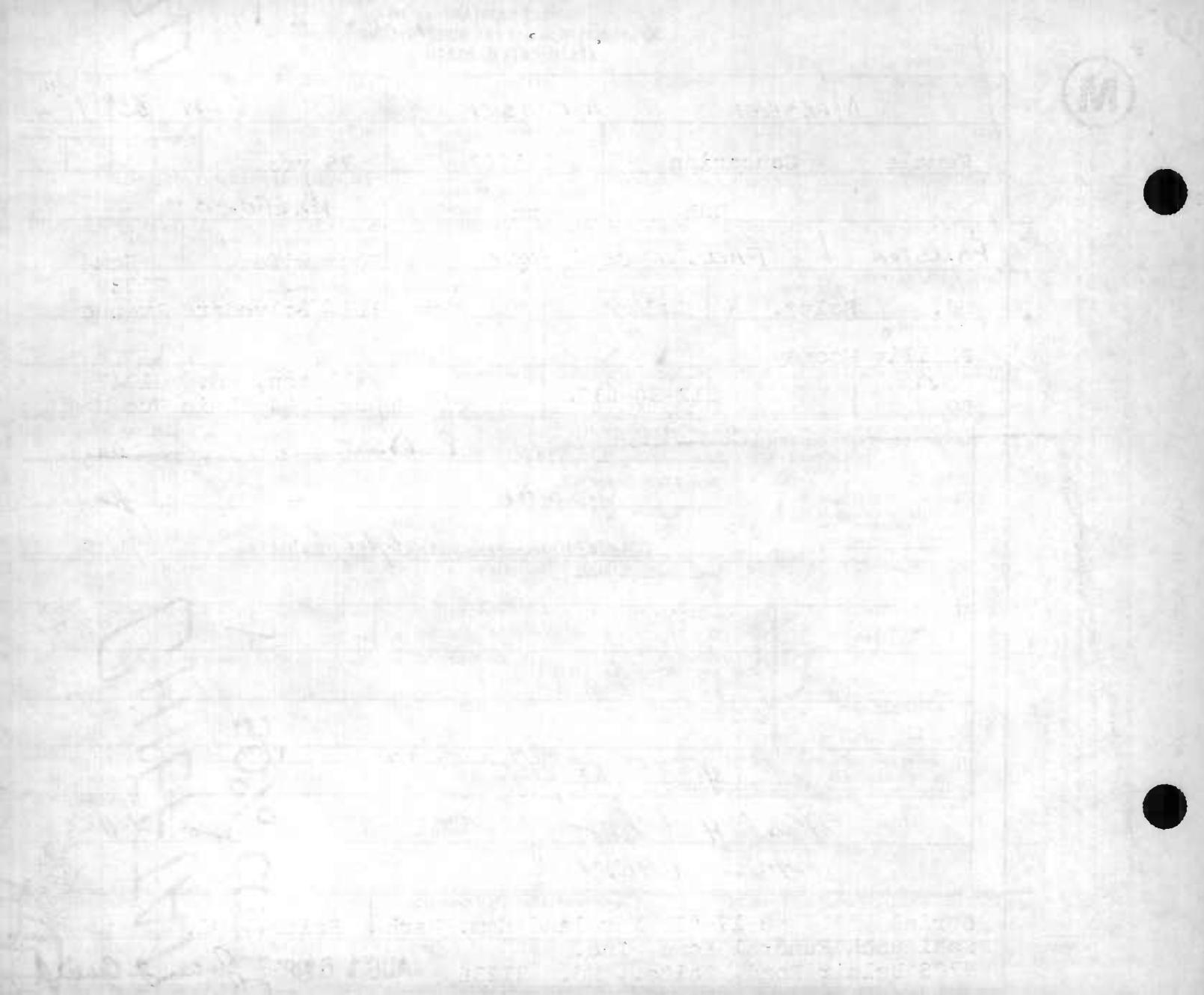
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, item 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21909		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
MARGARET			MORASKI			8 14 83			1 PM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 75 yrs. YRS.			
Female			Caucasian			2-2-1908			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS East 21239 1614/Belvedere Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Mary ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-0136			17. INFORMANT			ADDRESS Fallston, Md. 21047 Valerie Weber 1804 Plain Vue Way			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) meningitis - E. Coli DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 21a. DATE OF OPERATION										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
22a. I certify that (I) (this hospital) attended the deceased from 8/14/83 to 8/14/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8/14/83		
22b. SIGNATURE <i>Paul H. Chew</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL CHEN			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8-17-83			23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park			23d. LOCATION CITY OR TOWN Balto., Md. COUNTY STATE			
24. FUNERAL HOME Schimunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236			25a. DATE REC'D. BY REGISTRAR AUG 1 6 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

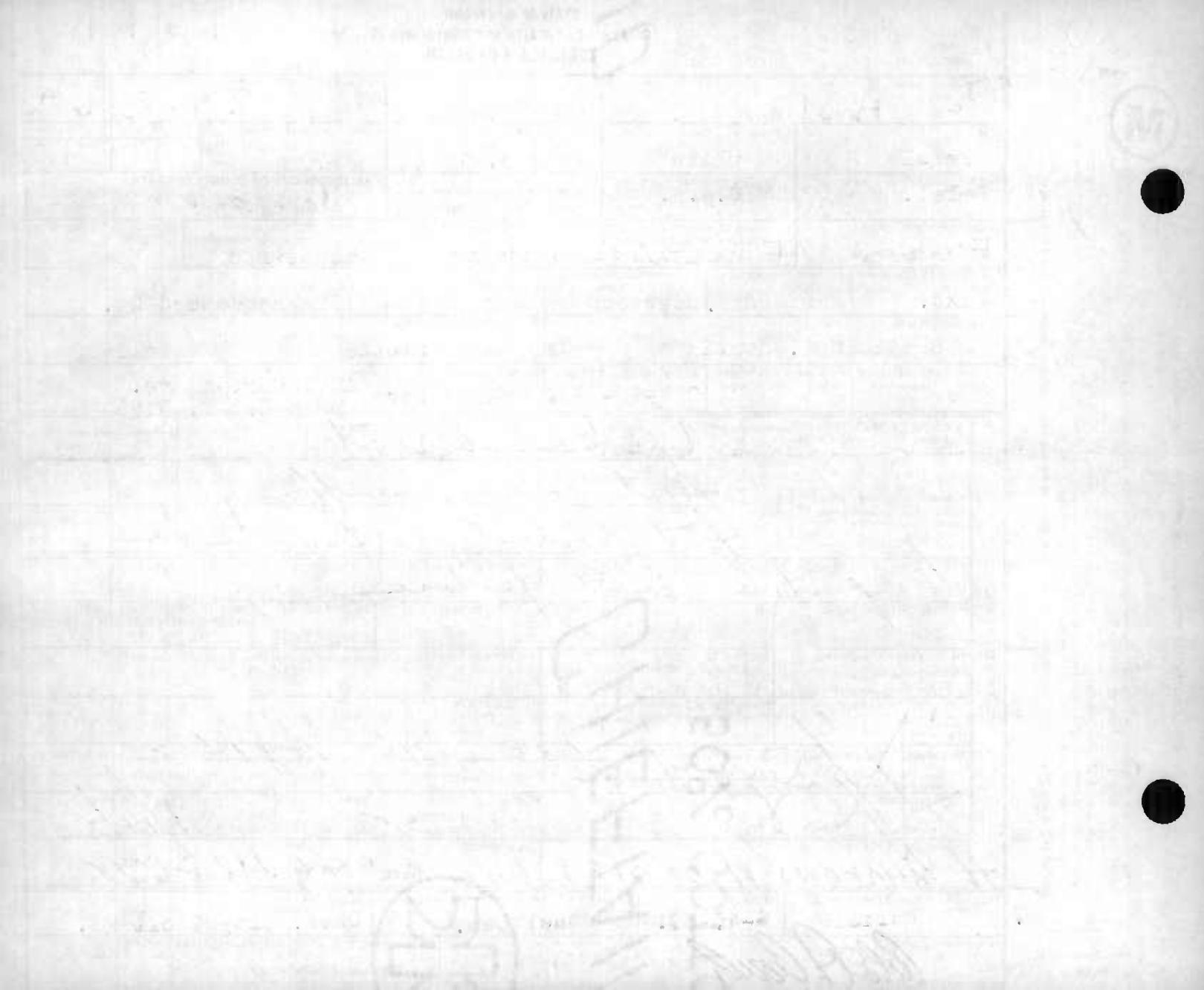
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 83-21910						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8 16 83									2b. HOUR 743 PM						
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			6. AGE (IN YEARS LAST BIRTHDAY) MONTH YRS. 81			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
JOSEPH HENRY NECKER Sr.																		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR June 8, 1902			6. CITIZEN OF WHAT COUNTRY? USA			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. to Postmaster- US Postal Service			12b. KIND OF BUSINESS OR INDUSTRY Service			
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2304 Rock Spring Road 21050						
14. FATHER'S NAME FIRST MIDDLE LAST Martin Adolph Necker			15. MOTHER'S MAIDEN NAME Christina												Neumeister			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 216-07-1153			17. INFORMANT Mrs. Sarah T. Necker, 2304 Rock Spring Road			ADDRESS Forest Hill, Md. 21050									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS																		
DUE TO, OR AS A CONSEQUENCE OF (b) STROKE												~ 5 yrs						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (this hospital) attended the deceased from 8/16/83 to 8/18/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.																		
22b. SIGNATURE Roy H. Phillips			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									22d. DATE SIGNED 8/17/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy H. Phillips			22e. ADDRESS 1716 Harford Road Fallston, Md. 21047															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 19, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Christ Episcopal Cem. Rock Spring			23d. LOCATION CITY OR TOWN Forest Hill			COUNTY Harford		STATE Md.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009									25a. DATE REC'D. BY REGISTRAR AUG 19 1983			25b. REGISTRAR'S SIGNATURE John J. Canfield						

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TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 83 21911
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH 8 14 83									2b. HOUR 6 A M
1. DECEASED NAME FIRST MIDDLE LAST			Amelia S. NICKERSON			2b. DATE OF DEATH MONTH DAY YEAR			8 14 83			2b. HOUR 6 A M
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			June 3, 1904			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.
7a. BIRTHPLACE STATE OR FOREIGN COLD Del.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21040 1724 Meadowood Ct.
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Benjamin P. Sartin			Henrietta Bolden									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-20-5354			17. INFORMANT Dallas Lore			ADDRESS 4071 Corona Ave. Norco Calif. 91760			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbone arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF: (b) <i>acute coronary suffocation</i>												
DUE TO, OR AS A CONSEQUENCE OF: (c) <i>arterio-venous carbo anoxia from congestive heart failure</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1983, to Aug 14 1983, that (I) (we) last saw the deceased alive on Aug 14 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death,												
22b. SIGNATURE <i>John J. Kowalski</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 8/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Kowalski M.D.</i>			22e. ADDRESS <i>1100 Avenue of the Americas New York NY 10036</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-15-83.			23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cem.			23d. LOCATION CITY OR TOWN Ches. City Cecil Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Robert C. Clegg</i>			ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Kowalski</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21912				
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST <i>Genevieve Phenomena O'Donnell</i>									2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <i>8 23 1983</i>			2b. HOUR <i>5 p.m.</i>	
3. SEX F			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR <i>5 9 12 71</i>		6. AGE (IN YEARS LAST BIRTHDAY) 71 yrs.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>8 23 1983</i>			2d. HOUR <i>8 p.m.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			MD.					
10. CITY OR TOWN OF DEATH <i>Edgewood</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) <i>1952 Melvin Dr.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>In Own Home</i>							
13a. STATE <i>Md</i>			13b. COUNTY <i>HARFORD</i>			13c. CITY OR TOWN <i>Edgewood</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>as above 21040</i>						
14. FATHER'S NAME FIRST <i>Patrick James</i>			MIDDLE <i>Nolan</i>			15. MOTHER'S MAIDEN NAME <i>Ellen Kirby</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE VETERAN DATES) <i>No 218-24-8154</i>			17. INFORMANT <i>Judith A O'Donnell Daughter</i>			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) <i>ASCVD - DIABETES</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														TITLE (SPECIFY) <i>Levi E. Sevole M.D. Deputy Medical Examiner</i>		
ACTUAL SIGNATURE <i>Levi E. Sevole</i>														DATE SIGNED <i>8-27-83</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Levi E. Sevole M.D.</i>			ADDRESS <i>464 Allegany St. Havre de Grace</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8-27-1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <i>James F. Scarpelli</i>			ADDRESS <i>Cumberland, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 30 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Carrell</i>							
BP _____		DHMH-17 (VR A15 ME (5)) 15M 2/80														

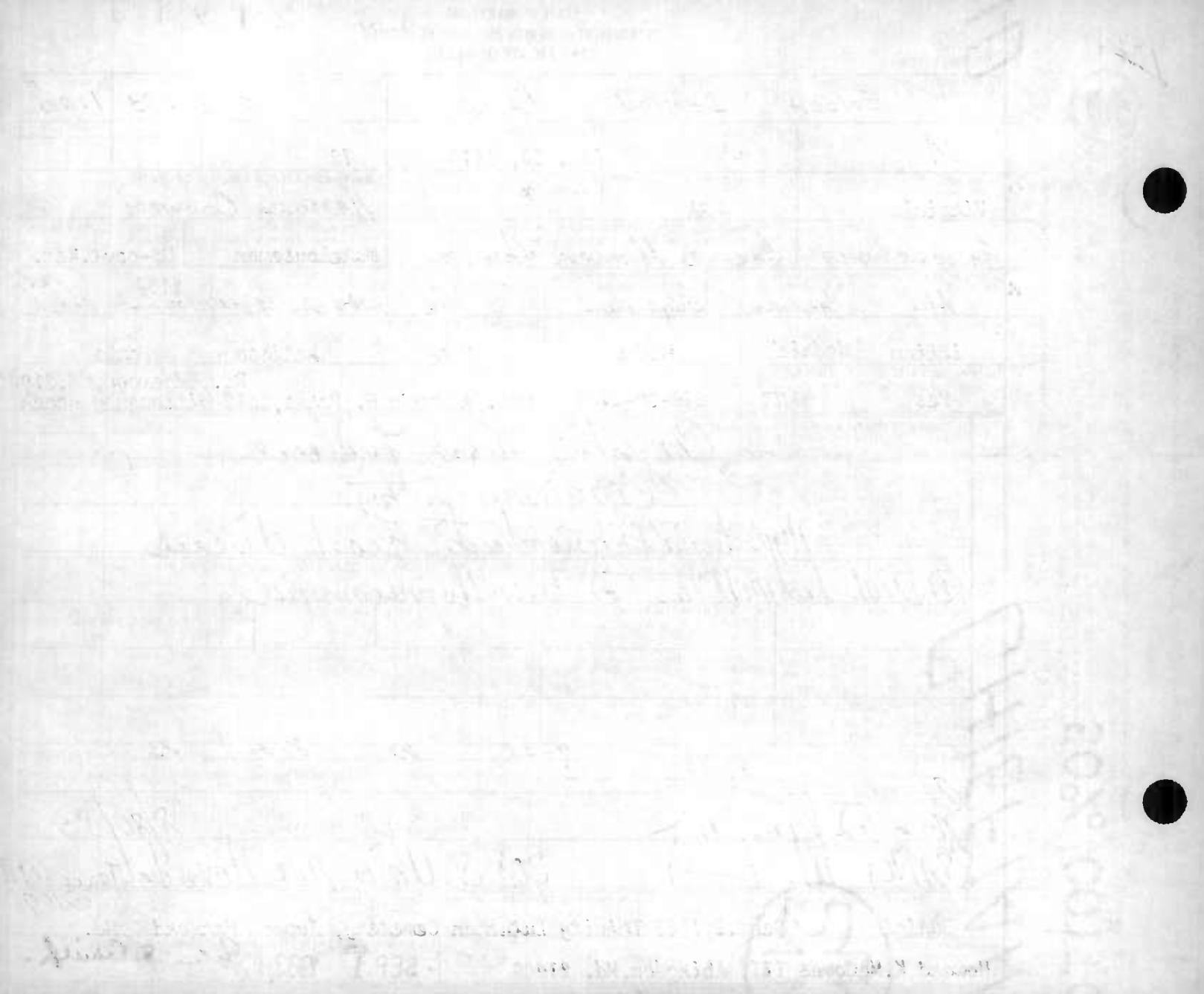
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be deposited for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8-321913		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8-30-83									2b. HOUR P 1:20 M		
1. DECEASED NAME FIRST Enoch MIDDLE Denton LAST Parks			2a. DATE OF DEATH MONTH DAY YEAR 8-30-83			2b. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			2c. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1910			6. IF UNDER 24 HRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.					
10. CITY OR TOWN OF DEATH HARVEY DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman			12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.					
13a. STATE Md			13b. COUNTY HARFORD			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21040 Rd. 2612, Willoughby Beach		
14. FATHER'S NAME FIRST William MIDDLE Hedrick LAST Parks			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Melissa LAST Parks											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT Mrs. Gertrude E. Parks, 2612 Willoughby Beach						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Arteriosclerotic heart disease														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ① Diabetes mellitus ② Bronchopneumonia														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7-25, 1982, to 8-30, 1983, that (I) (we) last saw the deceased alive on 8-30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22c. DATE SIGNED 8/30/83														
22b. PHYSICIAN'S NAME (TYPE OR PRINT) SANG J. KIM			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 2, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran Cemetery, Toppa			23d. LOCATION CITY OR TOWN Harford COUNTY Md.			23e. DATE REC'D. BY REGISTRAR SEP 1 1983		
24 FUNERAL DIRECTOR NAME Howard K. McComas III, ADDRESS Abingdon, Md. 21009												25b. REGISTRAR'S SIGNATURE John G. Conwell		

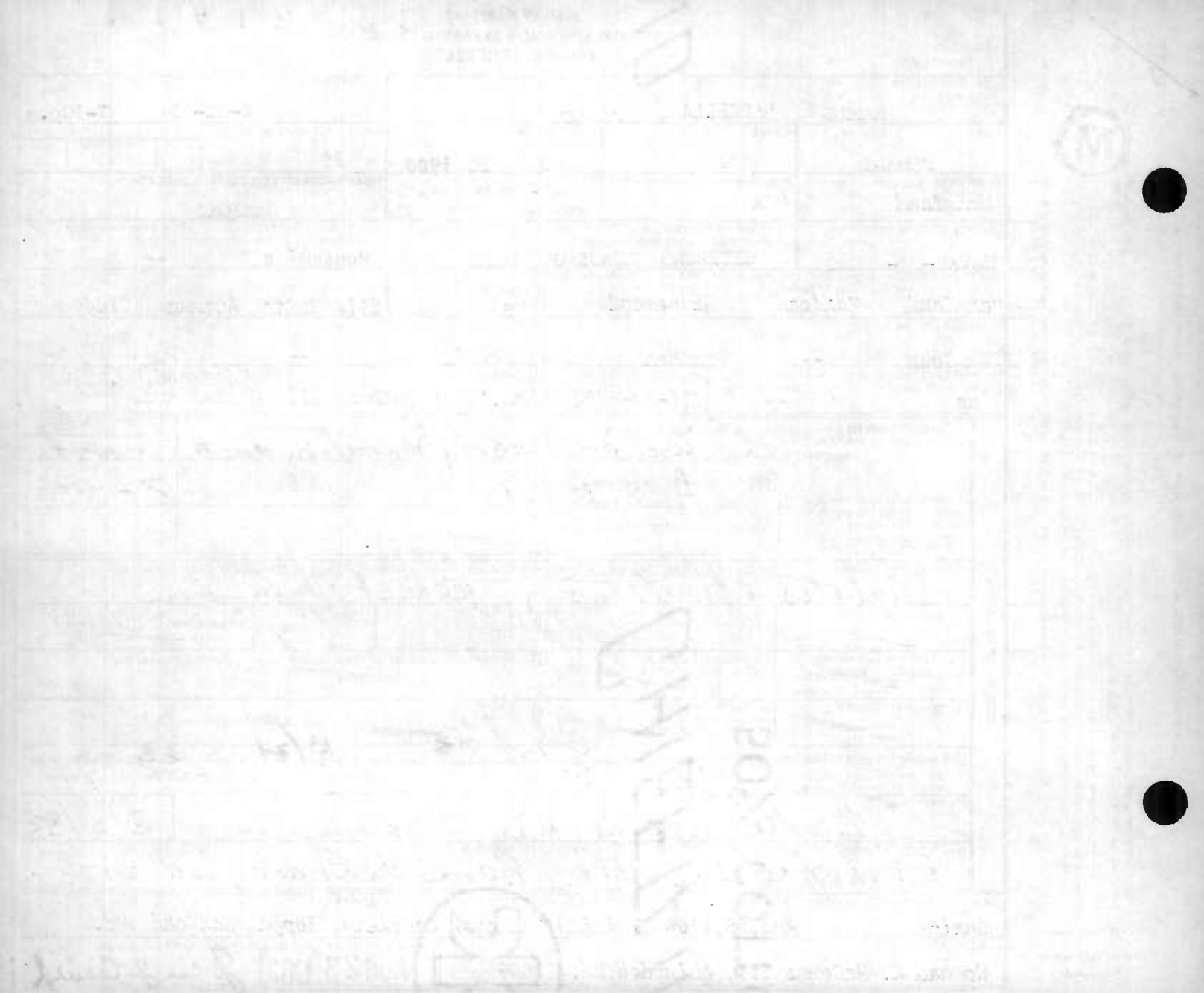


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8321914				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8-21-83									2b. HOUR 7-30p.m.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARCELLA			MIDDLE PEARCE			LAST							
3. SEX FEMALE			4. RACE W			5. DATE OF BIRTH MONTH 10 DAY 20 YEAR 1900			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.							
10. CITY OR TOWN OF DEATH HAVRE-DE- GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME			12a. USUAL OCCUPATION Housewife			12b. KIND OF BUSINESS OR INDUSTRY --							
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2114 Nuttal Avenue 21040				
14. FATHER'S NAME John			FIRST MIDDLE Gunther			LAST			15. MOTHER'S MAIDEN NAME Mollie			Puff				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-54-0794			17. INFORMANT Mrs. Ellen Burbar, 2114 Nuttal Ave,			ADDRESS Edgewood, Md. 21040			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation due to</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A.S.C.V.D.</i> { DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>															>2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I <i>Diabetes Mellitus, Recent Pneumonia.</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d. LOCATION CITY OR TOWN 8/21/83 COUNTY STATE							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION CITY OR TOWN 8/21/83 COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>8/21/83</i> to <i>8/21/83</i> , that (I) (we) last saw the deceased alive on <i>8/21/83</i> at <i>1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>8/21/83</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWARD C. Loo, M.D.</i>			22e. ADDRESS <i>Havre de Grace, Md. 21078-</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Aug. 25, 1983</i>			23c. NAME OF CEMETERY OR CREMATORIES <i>Trinity Lutheran Cemetery, Joppa Harford Md.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 23 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Conine</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8-3 2 1 9 1 5				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
WILLIE					PERKINS	8-12-83						M		
3. SEX		M	4. RACE		B	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
						1 27 32						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		n Carolina	7b. CITIZEN OF WHAT COUNTRY?		USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			HARFORD MD.		
10. CITY OR TOWN OF DEATH		Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		HARFORD Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Mechanic		
13a. STATE		Md.	13b. COUNTY		Harford	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
						Havre DeGrace						21078 400 Battery Drive		
14. FATHER'S NAME		FIRST Warren	MIDDLE	LAST Perkins	15. MOTHER'S M AIDEN NAME			FIRST Rosa	MIDDLE	LAST Lee				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DEATH) 4100		37-40-1605	17. INFORMANT			ADDRESS					
						Sandra Perkins same as above								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8-12-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			8-7-83 to 8-12-83											
22b. SIGNATURE <i>John D. Yen</i>			DEGREE						22c. DATE SIGNED 8/12/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Yen</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/19/83			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		
												23d. LOCATION CITY OR TOWN North East Cecil Md.		
24. FUNERAL DIRECTOR NAME Arnold Beard			ADDRESS Havre de Grace, Md.			25a. DATE REC'D. BY REGISTRAR AUG 23 1983			25b. REGISTRAR'S SIGNATURE <i>John D. Yen</i>					

RECEIVED

SEARCHED

INDEXED

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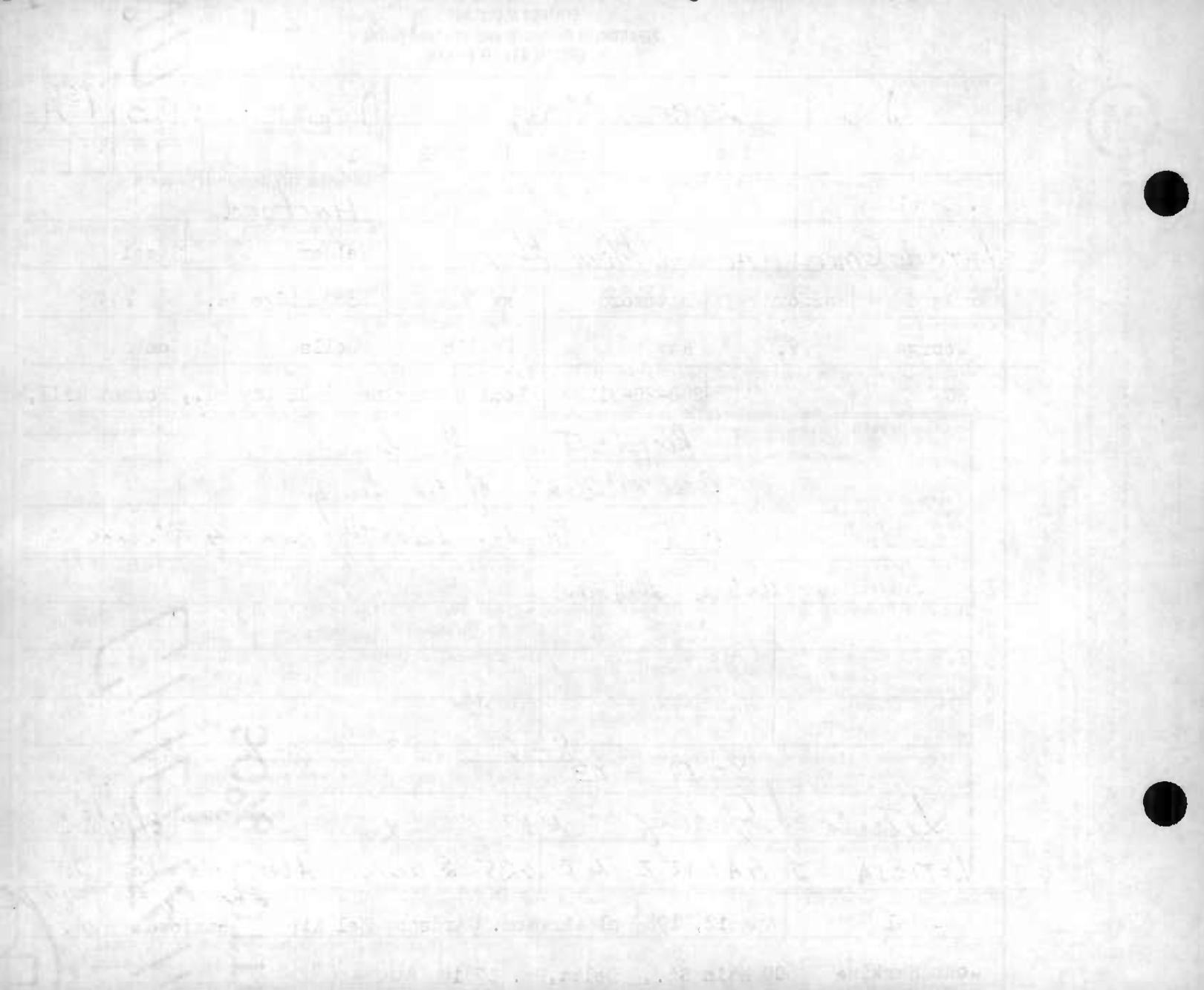
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APR 20 1968 FBI - LOS ANGELES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21916	
												REG. NO.	
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR	
			Joseph Oscar Ray						August 10, 1983			150 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White			JUNE 1 DAY 1912			71			MONTHS DAYS	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
N. Carolina			USA						Harford			YRS.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford de Grace			Hartford Mem. Hosp.			Welder			Steel				
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Whiteford			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1820 Ridge Rd. 21160	
14. FATHER'S NAME FIRST George			MIDDLE W.			LAST Ray			15. MOTHER'S MAIDEN NAME FIRST Sallie			LAST Belle Combs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			240-20-3116			Louise Harkins			2602 Ady Rd., Forest Hill, Md.				
18. CAUSE OF DEATH (Enter only one cause per line 18, (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>													
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the Lung</i>													
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulmonary Disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Artery Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-6, 1983, to 8-10, 1983, that (I) (we) last saw the deceased alive on 8-10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Leticia J. Galvez</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/10/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA J. GALVEZ M.D.			22e. ADDRESS 625 S. UNION AVE., HARFORD DE										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 12, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md.				
24. FUNERAL DIRECTOR NAME John Harkins			ADDRESS 600 Main St., Delta, Pa. 17314			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Connelly</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. J. RETAIN PAGE 3 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 72 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21917

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOSEPH	MIDDLE ANGELO	LAST RICCI	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 8-26-83 19	MONTH XX	DAY 19	YEAR 1983	2b. HOUR 1PM
3. SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1961	6 AGE (IN YEARS LAST BIRTHDAY) 21 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 8 DAY 26 YEAR 1983	14. HOUR 1PM	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
10 CITY OR TOWN OF DEATH Pattison			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed,			12b KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1644 S. Charles St. Balto. Md. 21230		
4. FATHER'S NAME FIRST Nicholas			MIDDLE A.	LAST Ricci	15. MOTHER'S MAIDEN NAME FIRST Garnetta			MIDDLE M.	LAST Robinson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-82-9732			17. INFORMANT Mr. Nicholas A. Ricci, Same as above			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8/60 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:40PM 8-25-83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver of a car who lost control(blown tire)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgwy.			21f. LOCATION STREET Rt. 23 & Jolly Acres			CITY OR TOWN Belair	STATE Maryland	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Margarita Korell										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
TITLE (SPECIFY) M.D. Assistant										DATE SIGNED 8-27-83
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 29, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie			
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md.		ADDRESS 21230		25a. DATE REC'D. BY REGISTRAR AUG 30 1983			25b. REGISTRAR'S SIGNATURE John C. Cullen			

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

WAGGONER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8321918	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH DAY YEAR	2b. HOUR
<i>Leo Francis Richardson</i>			<i>Aug. 28, 1983</i>	<i>6 PM</i>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS
<i>Male</i>	<i>white</i>	<i>Sept. 18 1906</i>	<i>76</i>	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH		
<i>Pennsylvania</i>	<i>USA</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>HARFORD</i>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
<i>HAVRE de Grace</i>	<i>HARFORD Memorial Hospital</i>			<i>Retired</i>		
13. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		
<i>Maryland</i>	<i>Harford</i>	<i>Aberdeen</i>	<input checked="" type="checkbox"/>	<i>39 Royal Terrace 21001</i>		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE
<i>Marshall</i>	<i>L.</i>	<i>Richardson</i>		<i>Mary</i>	<i>Elizabeth</i>	<i>Trace</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
<i>No</i>	<i>138-05-8157</i>	<i>Mary V. Richardson, 39 Royal Terrace, Aberdeen, Maryland 21001</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Chronic obstructive pulmonary disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i> (2) <i>Diabetes mellitus</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (1) <i>Arteriosclerotic heart disease</i> (2) <i>Diabetes mellitus</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Sang W. Kim, MD</i> DEGREE						
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. DATE SIGNED <i>Aug. 28, 83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SANG W. KIM</i> 22e. ADDRESS <i>308 S. Union Ave. Havre de Grace, Md. 21078</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>08/29/83</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rosehill Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Hagerstown</i>	COUNTY <i>Washington</i>	STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A.</i>	ADDRESS <i>Aberdeen, Md. 21001-3399</i>	25a. DATE REC'D. BY REGISTRAR <i>SEP 2 - 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>			

10 SS saline, Devon, UK
semi desert, wet, coastal, inland

100% dry, 10% of non-porous soil, 100% sand, 0% clay

deserted, monsoon, savanna, Lincoln, USA, Latin America

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the funeral director or removal company.

With the Store Dept. of Health and Mental Hygiene prior to being removed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 1 9 1 9			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Sr.	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Robert J.					Rosensteel	Sr.	8 19 83			150			150 P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		White		MONTH	DAY	YEAR	78			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MARYLAND		USA					HARFORD COUNTY								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Balt. City					
BEL AIR		BEL AIR CONVALESCENT CTR		CLER TRANSIT											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21213			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		2717 CHESTERFIELD AVE					
Maryland				BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	MAHER					
JOSEPH		L.		ROSENSTEEL	MARY		Agnes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		216-05-2650		BEL AIR CONVALESCENT CTR											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 4860															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 10 19 _____ that (I) (we) lost saw the deceased alive on _____ above, (I) (we) (do) (did not) view the body after death															
22b. SIGNATURE <i>John J. Ruck</i> DEGREE												THE ONE SIGNED <i>John J. Ruck</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
Burial		Aug 22 1983		Parkwood Cemetery		125 N Main St		County		State Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE					
Burial		Aug 22 1983		Parkwood Cemetery		Baltimore		AUG 22 1983		<i>John J. Ruck</i>					
24. FUNERAL DIRECTOR NAME		ADDRESS													
Leonard J. Ruck, Inc.		Baltimore, Maryland													

20% GELATIN



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be called or consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 21 1983							
										REG. NO.							
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		<i>Elizabeth B.</i>							<i>Schaeffer</i>		Aug 5 1983				8 42	P.M.	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 12 HRS				
Female		white			JAN 7, 1925			58			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.						
Pennsylvania		USA						<i>Hartford</i>									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
<i>Havre de Grace</i>		<i>Hartford Memorial Hosp</i>						<i>Homemaker</i>									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Md.		Cecil		<i>Port Deposit</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			27 Red Barn Rd.								
14. FATHER'S NAME FIRST		MIDDLE			LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
John		Leo			Shafransky		Florence		Mae		Shirry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS									
NO		206-12-7527			Dolores Buchanan, Ontario St., Ext.			<i>Havre de Grace, MD 21078</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4149 DUE TO, OR A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 5</i> , 1983, to <i>Aug 5</i> , 1983, that (I) (we) last saw the deceased alive on <i>Aug 5</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, check here.)																	
22b. SIGNATURE <i>Leticia S. Galvez, M.D.</i>										DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/6/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>625 S. UNION AVE. HAVRE DE GRACE</i>															
LETICIA S. GALVEZ, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Cremation/Removal		7 AUG 1983		Cratin and Ferris				<i>West Chester</i>		<i>Chester</i>		<i>PA</i>					
24. FUNERAL DIRECTOR NAME		ADDRESS <i>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</i>								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John L. Cawie</i>					
										AUG 10 1983							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21921			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
DORA VIRGINIA SCOTT						08 20 83			08	20	83	8:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		B		MONTH	DAY	YEAR	83			MONTHS	YEARS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford MD.			
MD		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston		Fallston General Hospital		Domestic			Port. Fam.						
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.		Harford					137 Alicia Ann St. 21014						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
Charles R. Scott				Henretta									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
no		220305323		Viola J. Scott, Bel Air, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													
PROBABLE Unknown - ASPIRATION													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 8/10/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ULCER (R) LEG.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8-18 19 83			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>8-18 19 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										8/20/83			
22b. SIGNATURE A. M. GUSS, M.D.		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 8/21/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. M. GUSS, M.D.		22e. ADDRESS 3900 N. CHARLES, BALTIMORE, MD 21218											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 24 1983			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion U.M. Cemetery		23d. LOCATION CITY OR TOWN Gwynedd, Harford, Md.						
24. FUNERAL DIRECTOR NAME Otha J. Bullock - Home de Grace, Md.		ADDRESS			25a. DATE REC'D BY REGISTRAR/25b. REGISTRAR'S SIGNATURE AUG 22 1983 John J. Conroy								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 of 4

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please seal it in an envelope and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. This certificate should be detached from the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21922						
												REG. NO.						
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Virginia			Jessie			Seiser			8		11	83	7:30 PM		
3. SEX			Female			4. RACE			white			5. DATE OF BIRTH MONTH DAY YEAR		Jan. 22, 1922			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE COUNTRY			Maryland			7b. CITIZEN OF WHAT COUNTRY?			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.			IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Havre de Grace			Hartford Memorial Hospital			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Hartford			13c. CITY OR TOWN Joppa						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 607 Trimble Rd. 21085				
14. FATHER'S NAME FIRST			Raymond			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Emma		LAST			Challoner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 220-14-5689			17. INFORMANT Sr. Thomas O. Seiser, 607 Trimble Road, Joppa, Md.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4254			caused by						caused by			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DOUE TO, OR AS A CONSEQUENCE OF (b)						caused by						
						DOUE TO, OR AS A CONSEQUENCE OF (c)						caused by						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COPD.																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (he/she/we) attended the deceased from <u>Feb</u> , 19 <u>83</u> , to <u>8-11</u> , 19 <u>83</u> , that (II) (we) last saw the deceased alive on <u>8-11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>M. S. Sharaf ELOEANE</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED August 11, 1983									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. SHARAF ELOEANE			22e. ADDRESS South Union Ave, Havre de Grace Md.															
23a. BURIAL, CREMATION, REMOVAL 1SP Burial			23b. DATE Aug. 15, 1983			23c. NAME OF CEMETERY OR CREMATORIAL BelAir Memorial Gardens			23d. LOCATION Bel Air Hartford Md.									
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR AUG 15 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>												

14

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IN THE OFFICE OF THE
CIRCUIT CLERK OF THE
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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FOR THE DISTRICT OF COLUMBIA

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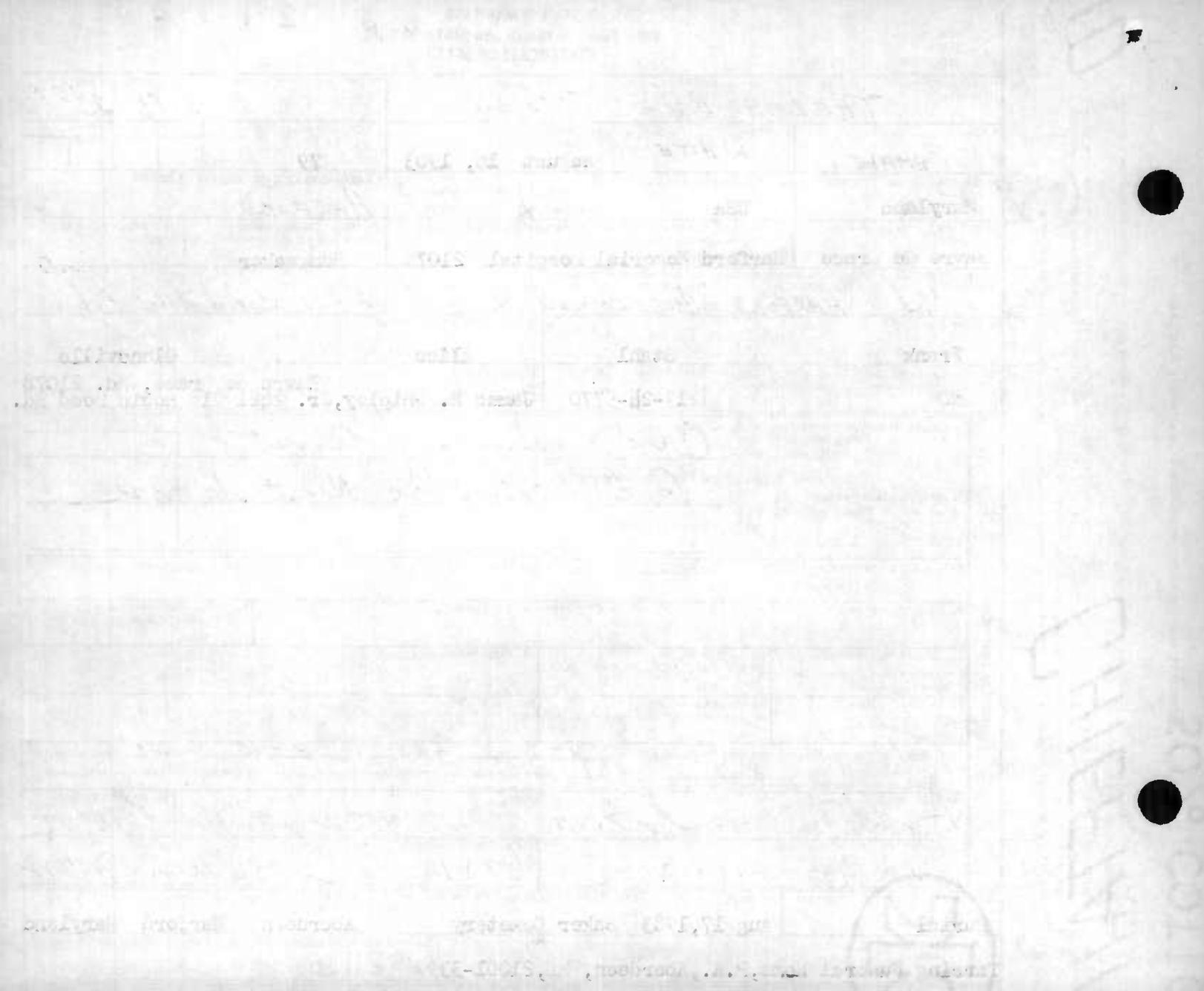
RECEIVED
U.S. DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8-3 21923			
												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			THELMA RACHEL SHIPLEY						8-15-83			2:28 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			7. IF UNDER 24 HRS. HOURS MIN.					
FEMALE		WHITE		August 18, 1903			79 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.								
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital 21078		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2421 Robin Hood Rd.					
14. FATHER'S NAME FIRST Frank		MIDDLE Stahl		15. MOTHER'S MAIDEN NAME FIRST Alice			LAST Glandville								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-25-5770		17. INFORMANT James H. Shipley, Jr. 2421 Old Robin Hood Rd.			ADDRESS Havre de Grace, Md. 21078			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arterio-occlusive Heart disease</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART II)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>7-9</i> , 19 <i>83</i> , to <i>8-15</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>8-15</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>8/16/83</i>			
22b. SIGNATURE <i>H. Smith, M.D.</i>		22c. DEGREE MONAIC			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONAIC		22e. ADDRESS Havre de Grace Md 21078													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 17, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Baker Cemetery			23d. LOCATION CITY OR TOWN Aberdeen County Harford Maryland								
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3309		25a. DATE REC'D. BY REGISTRAR AUG 23 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Caswell</i>										

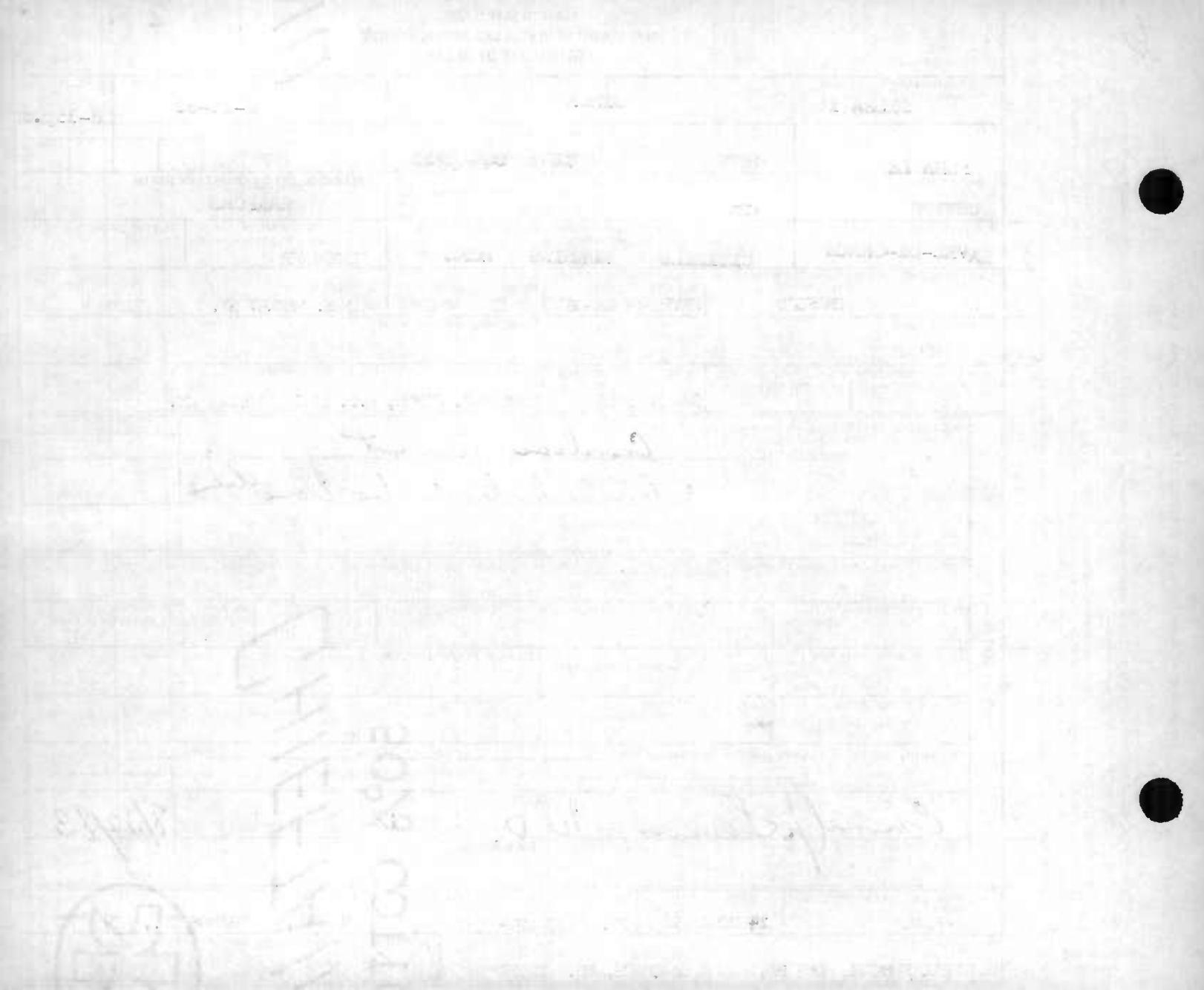


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 1 9 2 4							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
SIMLA Y						SIMON						8-21-83						8-35 p.m.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMA LE			WHITE			MONTH DAY YEAR			107			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEBONAN			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.										
10. CITY OR TOWN OF DEATH HAVRE-DE-GRAVE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CITIZENS NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVRE de GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 415 S. MARKET ST. 21078							
14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ZEKIA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 068 38 9085			17. INFORMANT			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292						Cardiac Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DOUE TO, OR AS A CONSEQUENCE OF (b) arterio sclerotic cardio vascular disease																
			DOUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8/22/83							
22b. SIGNATURE Edmund J. Simon			22c. DEGREE Dr.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 24 AUGUST 83			23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CEMETERY			23d. LOCATION CITY OR TOWN GOSHEN, COUNTY ORANGE CO., STATE NEW YORK										
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			25a. DATE REC'D. BY REGISTRAR AUG 25 1983			25b. REGISTRAR'S SIGNATURE John J. Cenrich													



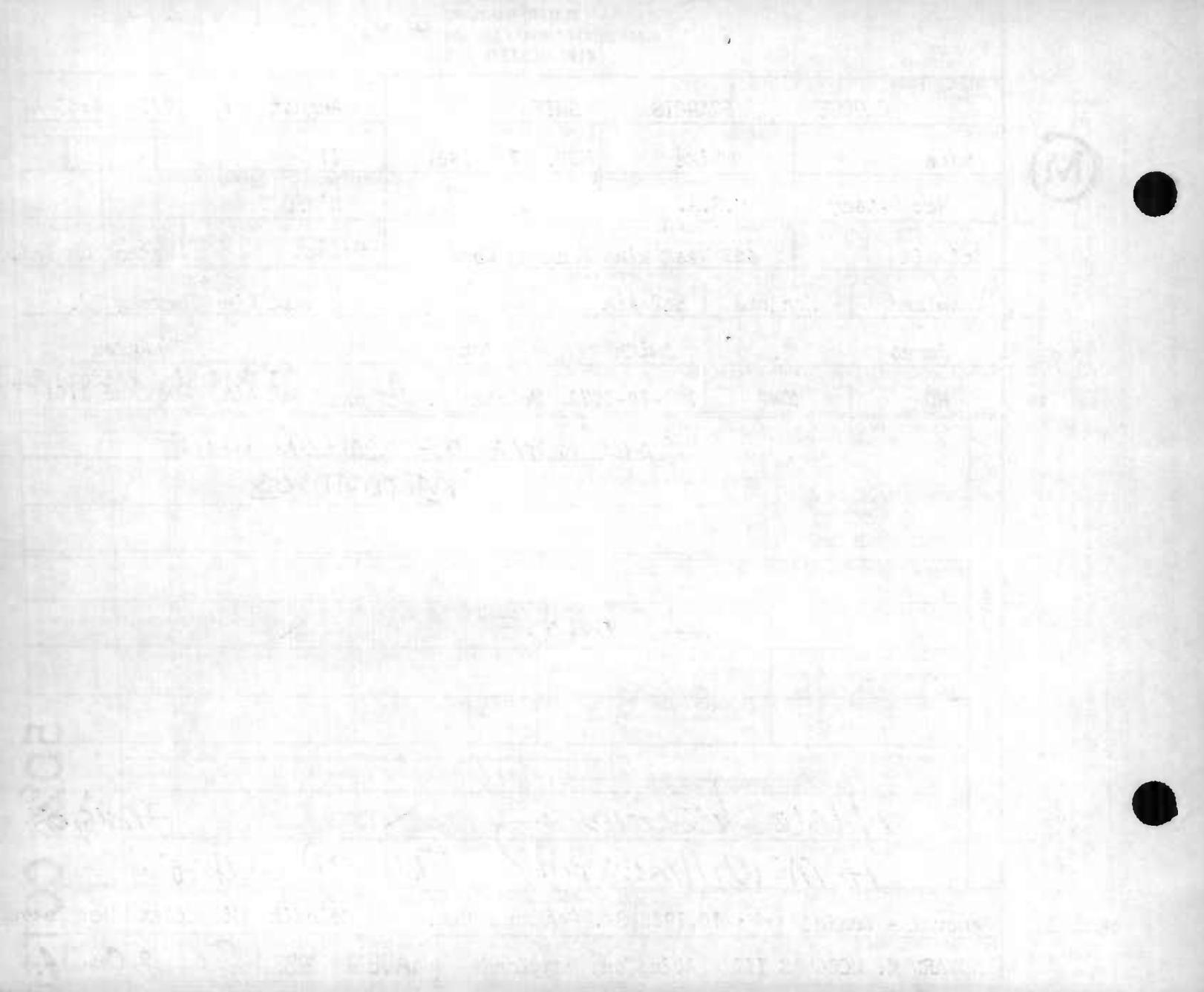
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 21925
1 - FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST GEORGE	MIDDLE FRANCIS	LAST SMITH	2a. DATE OF DEATH MONTH DAY YEAR August 7, 1983
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR NOV. 7 1901		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 81 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 West Ring Factory Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21014 603 West Ring Factory Rd.
14. FATHER'S NAME FIRST James		MIDDLE B.	LAST Smith	15. MOTHER'S MAIDEN NAME FIRST Sarah	MIDDLE LAST Thornton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Dolores M. McShane	ADDRESS 603 West Ring Factory Rd. Bel Air, Maryland 21014
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon w/1F 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED See above			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. McWilliams, MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) H. McWilliams, MD ADDRESS Fallston G. Hospt.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal - Burial		23b. DATE AUG. 10, 1983	23c. NAME OF CEMETERY OR CREMATORIAL St. Gertrude Cem.	23d. LOCATION CITY OR TOWN Colonia COUNTY MIDDLESEX New Jersey	
24. FUNERAL DIRECTOR HOWARD K. MCCOMAS III		25a. DATE REC'D. BY REGISTRAR AUG 9 1983	25b. REGISTRAR'S SIGNATURE John J. Coniglio		



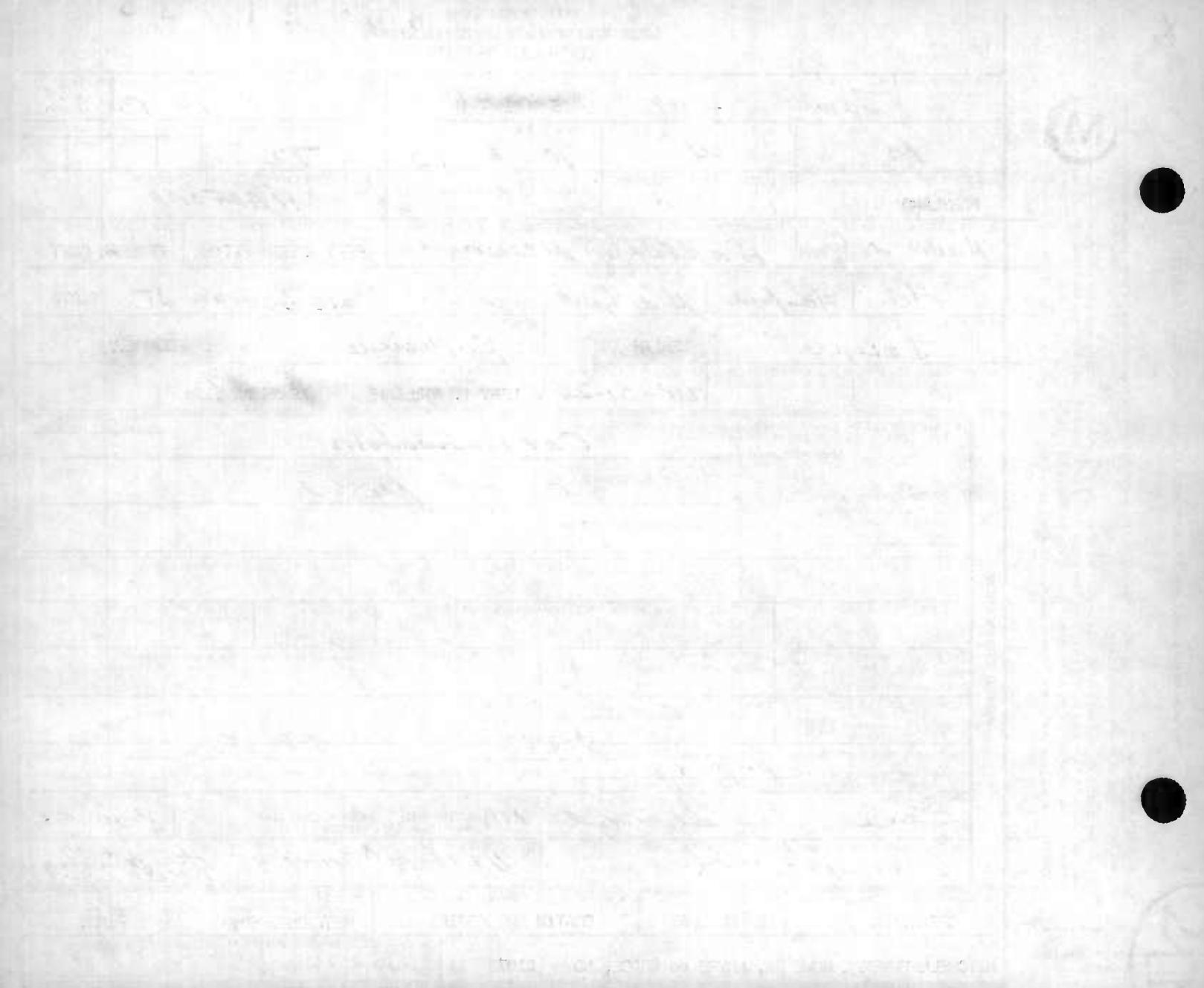
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

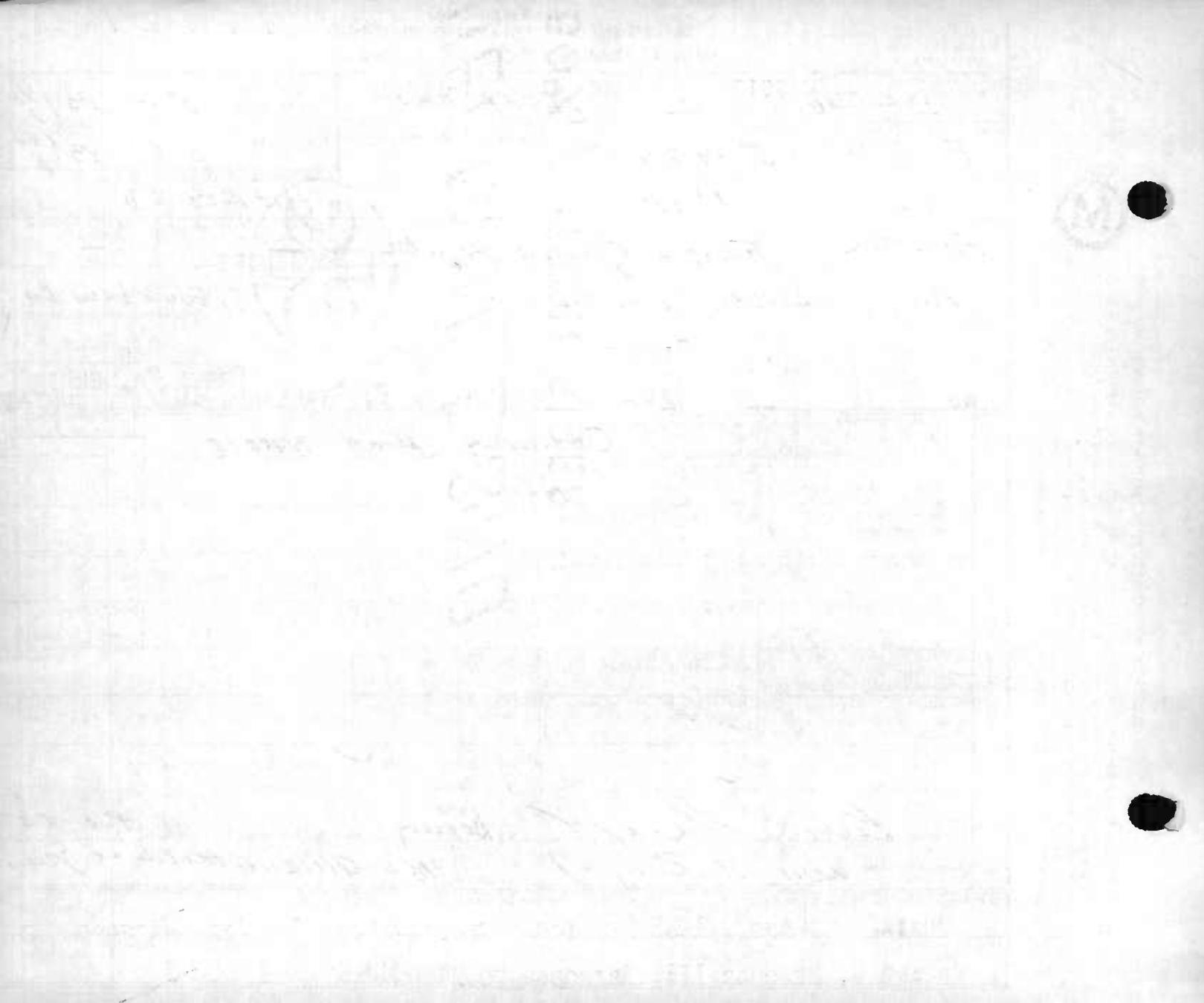
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.
1 - FOR STATE REGISTRAR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE <i>Leroy</i>	LAST <i>SMITH</i>	2a. DATE OF DEATH MONTH DAY YEAR 8 10 13
3. SEX <i>M</i>			4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR 10 6 10		2b. HOUR 8 ³⁰ AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) STEAM FITTER
13a. STATE <i>Md</i>			13b. COUNTY <i>Harfard</i>	13c. CITY OR TOWN <i>Havre de Grace</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 316 Bourbon St. 21078
14. FATHER'S NAME FIRST <i>Joseph</i>			MIDDLE <i>SMITH</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Katherine</i>		MIDDLE <i>DONNELLY</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>218-07-2698</i>	17. INFORMANT <i>MARY T. WILLIAMS</i>	ADDRESS SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1850</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca of prostat</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <i>8-2-53</i> , 19_____, to <i>8-10-13</i> , 19_____, that (1) (we) last saw the deceased alive on <i>8-10-13</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John E. Seeger</i>			DEGREE <i>MJ</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8-10-53</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lewis Kenyon</i>			22e. ADDRESS <i>464 Alluvium St Havre de Grace 21078</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11 AUG 1983	23c. NAME OF CEMETERY OR CREMATORIAL CRATIN AND FERRIS		23d. LOCATION CITY OR TOWN WEST CHESTER, COUNTY PENN.	
24 FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD			25a. DATE REC'D. BY REGISTRAR AUG 15 1983 25b. REGISTRAR'S SIGNATURE <i>John E. Seeger</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE HELD WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

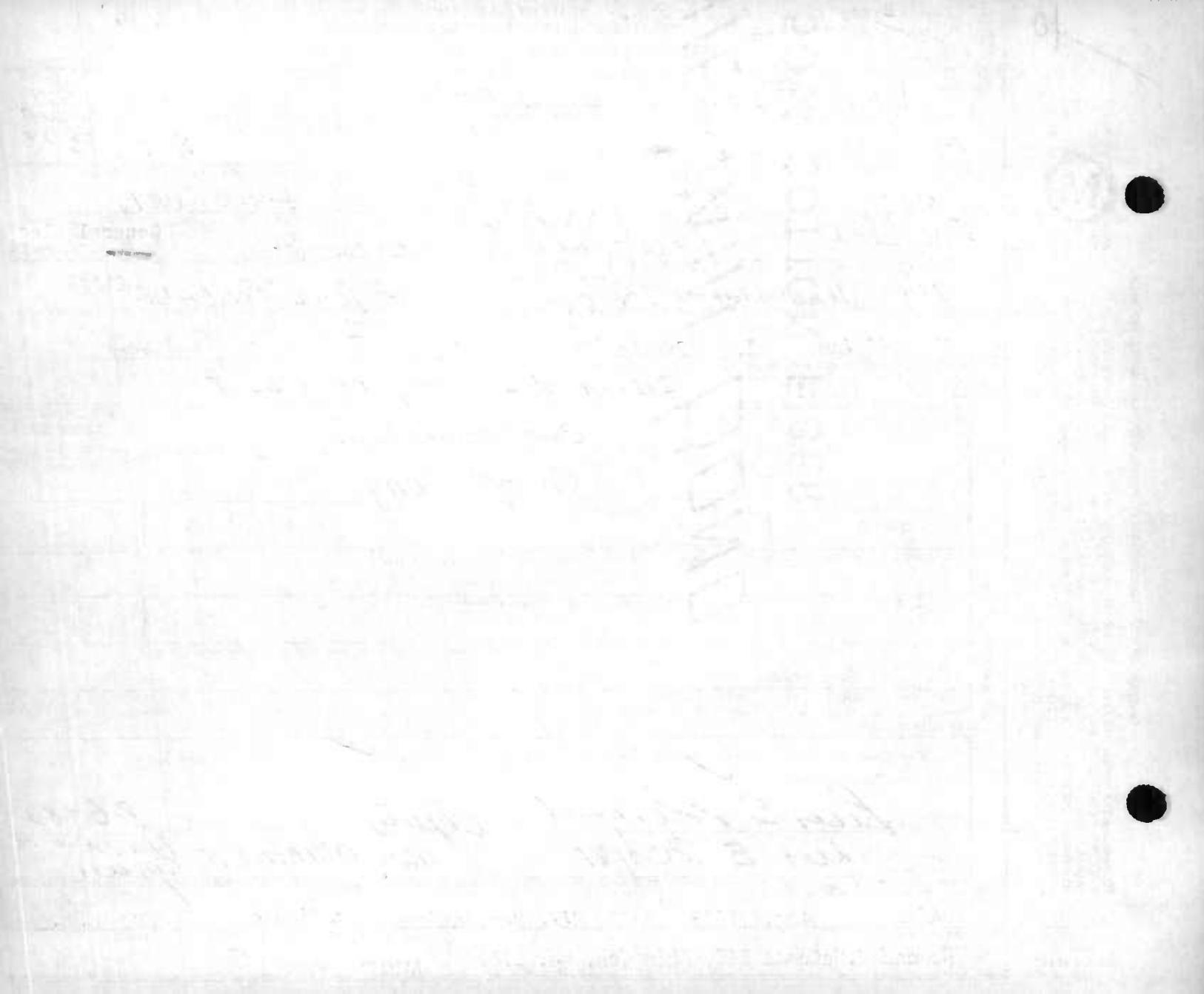
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												21921		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	DESSIE	MIDDLE	MAE	LAST	STALLARD	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR M	
3. SEX			RACE	F	W	S. DATE OF BIRTH MONTH DAY YEAR	5-14-24	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	59	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTH	86	1983
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED			MAE	USA	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	MONTH	DAY	YEAR	2d. HOUR M	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
FALSTON			HALSTON General Hospital			HOUSEWIFE			--					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MD			HARFORD			Bel Air			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1022 S. Fountain Rd		
14. FATHER'S NAME			FIRST	R.	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS				
GEORGE					PIERCE		RACHEL			GREEN RD. BELAIR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____ (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____			MD APPROXIMATELY BETWEEN ONE AND ONE-HALF MILES FROM THE DEATH SITE		
NO			230-28-5780			CHARLES E. STALLARD, 1022 S. FOUNTAIN RD.						MD 21014		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Luis E. Renfro</i>			TITLE (SPECIFY) M.D. <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>8-6-83</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E. Renfro</i>			ADDRESS <i>464 William Marion Grace</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE AUG. 9, 1983			23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION METHODIST CEM. BEL AIR HARFORD MD			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>John J. Tolson</i>					
BP _____														
DHMH - 17 (VR A15 ME (5)) 15M 2/80														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTED THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME				FIRST JOHN	MIDDLE THOMAS	LAST STARKEY	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 86	DAY 19	YEAR 83	REG. NO. 21928
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 23	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 60	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. HOUR 12 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. Hos		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Controllman		12b. KIND OF BUSINESS Generalist					
13a. STATE MA		13b. COUNTY HARFORD	13c. CITY OR TOWN Toppa	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1042 EUSTIS DR. 21085					
14. FATHER'S NAME FIRST - William J. Starkey		15. MOTHER'S MAIDEN NAME FIRST Lena				ADDRESS Schedel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-14-450		17. INFORMANT Hospital Clerk		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629		Causing condition (b) Ca of lung.		(c)							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE LEO E Renjel		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER Deputy		DATE SIGNED 8-6-83					
EXAMINER'S NAME (TYPE OR PRINT) LEO E Renjel		ADDRESS 464 Alluvium St		Glen Burnie Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 9, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill Mem. Gardens		23d. LOCATION CITY OR TOWN Baltimore					
24. FUNERAL DIRECTOR NAME Howard K. McComas III		ADDRESS Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR AUG 9 1983		25b. REGISTRAR'S SIGNATURE Jan. 9, 1983					
NAME VR A15 ME (51) 15M 2/80											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21924												
										REG. NO.												
1. FOR STATE REGISTRAR			FIRST CASIMER			MIDDLE A.			LAST SZEKALSKI			2a. DATE OF DEATH		MONTH 8	DAY 10	YEAR 83	2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)												6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 56		IF UNDER 24 HRS DAYS YRS						
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 3 - DAY 11 - YEAR 1927						7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD Co. MD.					
10. CITY OR TOWN OF DEATH JOPPATOWNE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 116 BREAKWATER COURT			12a. USUAL OCCUPATION WELDER			12b. KIND OF BUSINESS OR INDUSTRY STEEL Co.			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 116 BREAKWATER COURT 21085								
13a. STATE MD.			13b. COUNTY HARFORD			13c. CITY OR TOWN JOPPATOWNE						15. MOTHER'S MAIDEN NAME ALEXANDRA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES.			16b. SOCIAL SECURITY NO. W.W.II 219-16-7371		17. INFORMANT Mrs. Phyllis B. Szeckalski - 116 Breakwater Court		ADDRESS 21085 Court	
18. CAUSE OF DEATH (Enter only one cause per line for 18(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1889			18b. CONDITIONS FOR WHICH OPERATION WAS PERFORMED Bladder Cancer			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			(b)			(c)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N.A.										
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.			21f. LOCATION STREET N.A. CITY OR TOWN CITY OR TOWN N.A. COUNTY COUNTY N.A. STATE STATE																
22a. I certify that (I) (this hospital) attended the deceased from <u>1981</u> to <u>Aug 19</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Aug 19</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			22b. SIGNATURE Harry W. Smith			22c. DEGREE DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 10 Aug 83										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry W. SMITH			22e. ADDRESS 715 Shamrock Rd Bel Air			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-13-83			23c. NAME OF CEMETERY OR CREMATORIUM ST. STANISLAUS			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MD. STATE							
24. FUNERAL DIRECTOR NAME Hartley Miller - 7527 Harford Rd.			25a. ADDRESS ADDRESS			25b. DATE REC'D. BY REGISTRAR AUG 11 1983			25b. REGISTRAR'S SIGNATURE John J. Coniglio													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the attending Physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21930

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
GEORGE — TILLEY						8-4-83				12 30 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS					
Male			White			12 - 30 - 11			71 YRS.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.					
North Carolina			U.S.A.											
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant Postmaster			12b. KIND OF BUSINESS OR INDUSTRY U.S. Mail Service					
13a. STATE Maryland			13b. COUNTY Hartford Co.			13c. CITY OR TOWN BEL AIR			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 354 Crocker Street 21014		
14. FATHER'S NAME FIRST Elihu			MIDDLE 			LAST TILLEY			15. MOTHER'S MAIDEN NAME FIRST ELIA			MIDDLE REEVES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-4037			17. INFORMANT (NAME) Mrs L. Evelyn Tilley ADDRESS 354 Crocker Street Bel Air, Maryland 21014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT LOWER LUNG PNEUMONIA														
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF LEFT LUNG.														
{ DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LESS HEMIPLEGIA + CORONARY ARTERY DISEASE														
19a. DATE OF OPERATION 7/18/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ATROPHIASIS / PNEUMONIA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from July 9 1983 to Aug. 4 1983 , that (I) (we) last saw the deceased alive on August 4 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE A. J. SWEATMAN			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/4/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. SWEATMAN			22e. ADDRESS Fairfax Gen Hosp.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE August 6, 1983			23c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEMORIAL GARDENS			23d. LOCATION CITY OR TOWN BEL AIR, HARFORD CO., MARYLAND 21014					
24. FUNERAL DIRECTOR Joseph William Foster			25. DATE REC'D. BY MEDICAL REGISTRAR Aug 8 1983			25. REGISTRAR'S SIGNATURE John C. Clark								
26. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

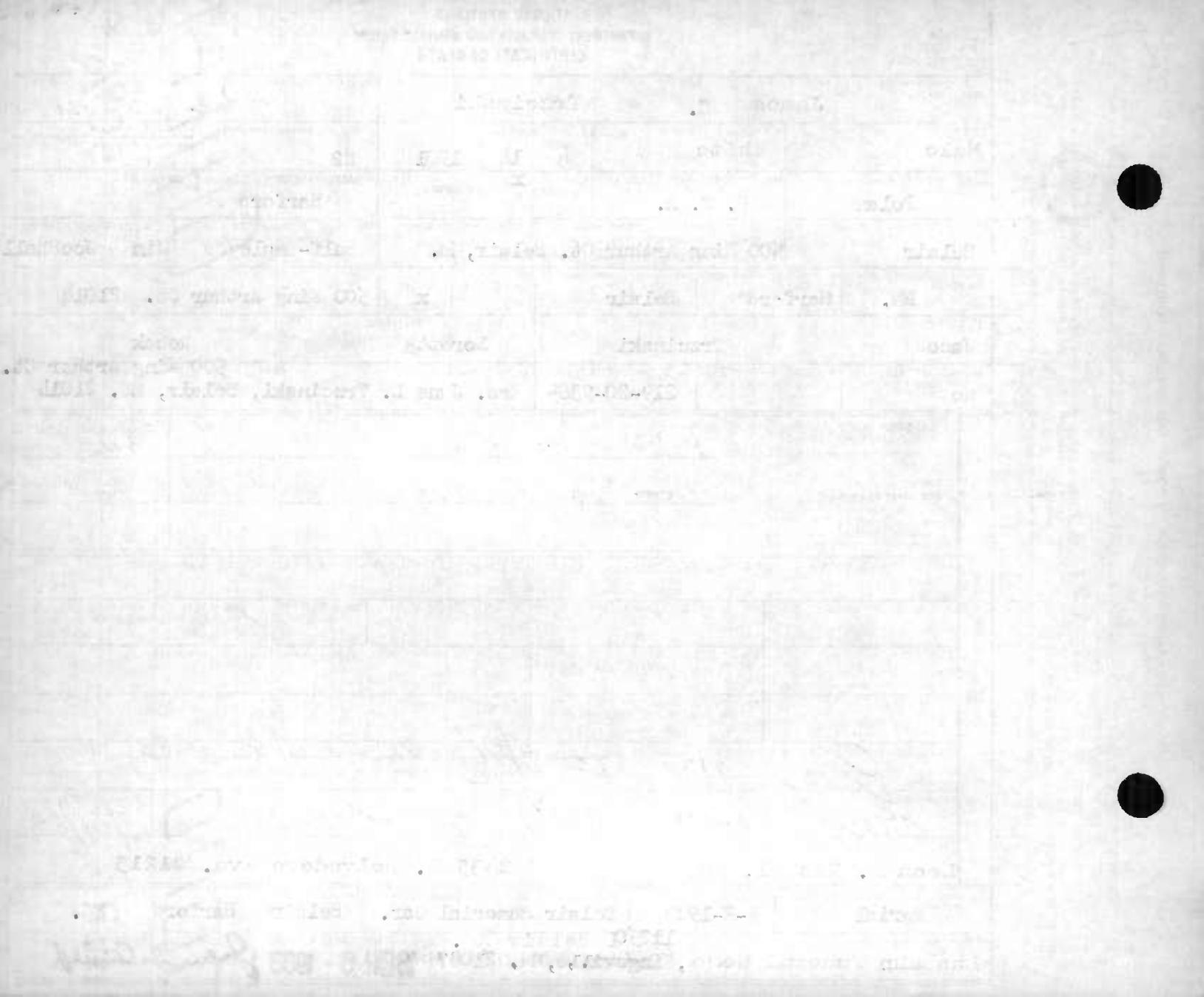
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21931						
										REG. NO.						
1 - FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		PRISCILLA DYE TROLLINGER								AUG, 29.83					1 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
female		WHITE		MONTH DAY YEAR				88		MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
MARYLAND		USA						HARFORD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
HAVRE DE GRACE		CITIZENS NURSING HOME				HOMEMAKER										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
MD		HARFORD		HAVRE de GRACE				900 SOUTH UNION AVENUE		21078						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
JOSEPH		E.		DYE		SADIE				SILLS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS								
NO		141 38 3100				MRS. EVELYN BARNES RD #1 BOX 16 SCOTTSVILLE, VA. 24590										
18. CAUSE OF DEATH (Enter only one cause per line for Part 1 or Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4100</i>										ANTERIOR/POSTERIOR INTERVAL TIME/ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCD</i> (c) <i>old age</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED <i>8/29/83</i>						
22c. SIGNATURE <i>John J. Tull</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Tull MD</i>										22e. ADDRESS	22f. LOCATION CITY OR TOWN			COUNTY	STATE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1 SEPTEMBER 83			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN			23e. COUNTIES				
										HAVRE de GRACE, HARFORD, MARYLAND						
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD 21078										25a. DATE REC'D. BY REGISTRAR SEP 2 - 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Tull</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 18 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

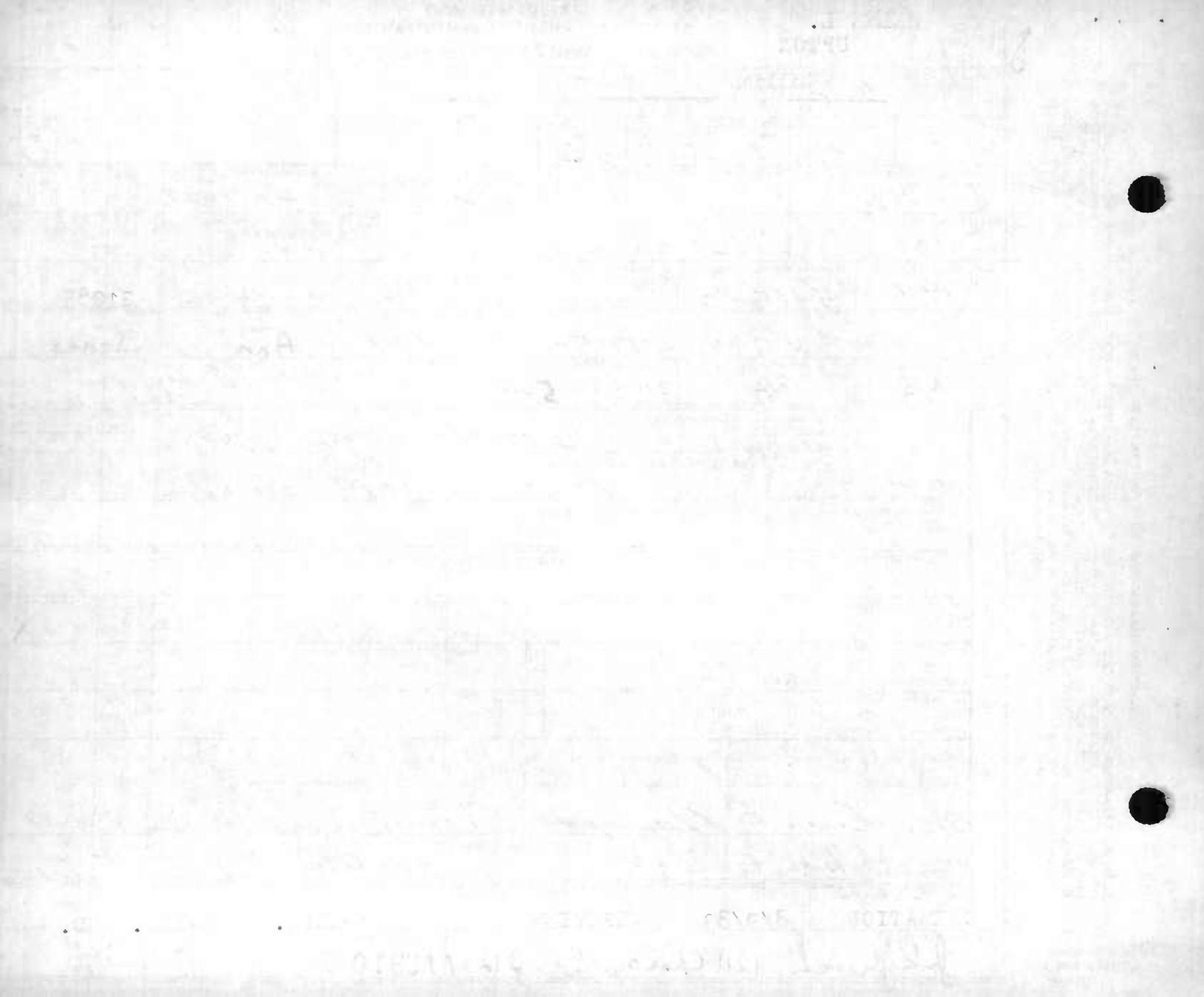
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	21932			
												REG. NO.				
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			7a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR
1. DECEASED NAME (TYPE OR PRINT)			James C.			Trzcinski						8/30/83				7P M
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH 4 DAY 14 YEAR 1901						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Belair			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 500 King Arthur Ct. Belair, Md.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed	12b. KIND OF BUSINESS OR INDUSTRY Jim & Joe Shell			
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Belair			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 500 King Arthur Ct. 21014				
14. FATHER'S NAME Jacob			MIDDLE LAST Trzcinski						15. MOTHER'S MAIDEN NAME FIRST Loretta			MIDDLE	LAST Robak			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-20-9365			17. INFORMANT Mrs. June L. Trzcinski, Belair, Md. 21014						ADDRESS 500 King Arthur Ct. 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos				
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c)												2 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) this hospital attended the deceased from <i>8/20</i> , 1983, to <i>8/30</i> , 1983, that (I) we last saw the deceased alive on <i>8/20</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												<i>3/21 1965 to 8/30 1983</i>				
22b. SIGNATURE <i>Leon E. Kassel, MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>8/31/83</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leon E. Kassel, MD			22e. ADDRESS 2435 W. Belvedere Ave. 21215													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-2-1983			23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gar.			23d. LOCATION CITY OR TOWN Belair			COUNTY Harford				
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, Kingsville, Md. 21087			1150 Belair Rd.			ADDRESS 1150 Belair Rd.			25a. DATE REC'D. BY REGISTRAR SEP. 6 - 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		HELEN L. UPTON		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		21933			
						REG. NO.			
2. DECEASED NAME (TYPE OR PRINT)		FIRST Lillian MIDDLE Helen LAST Upton		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 8	DAY 8		
3. SEX F		4 RACE W		5. DATE OF BIRTH MONTH 8 DAY 25 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 RS.		7a. HOUR 1pm M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		8. CITIZEN OF WHAT COUNTRY? USA		9. MARRIED WIDOWED		10. DATE PRONOUNCED DEAD		11. DATE MONTH 8 DAY 19 YEAR 1983	
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 125 Ravenswood Ct		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H-W		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY HALIFAX		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS as above 21085	
14. FATHER'S NAME FIRST John MIDDLE Wesley LAST Pittner		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ann LAST Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NA		16b. SOCIAL SECURITY NO. 218-09-5287		17. INFORMANT Harry C Upton ADDRESS 425 Ravenswood Joppa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD - DIABETIS - GLICOLOM.		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Luis E. Renjel</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel		ADDRESS 464 Alluvia St House # Gard 21071		DATE SIGNED 8-12-83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8/9/83		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW		23d. LOCATION CITY OR TOWN BALTO.			
24. FUNERAL DIRECTOR NAME <u>blyden</u>		ADDRESS 1215 Chesapeake Ave. - 21237		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 10 1983 John J. Conigli					
DHMH-17 (VA15 ME(5)) 15M 2/90									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21934			
										REG. NO.			
1. DECEASED NAME [TYPE OR PRINT]			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
SALVATORE			A.		VOZZELLA	8-25-83					8:50	A	
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M			W	MONTH JULY DAY 10, YEAR 1935	48			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] MASSACHUSETTS			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			MD.					
10. CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DENTIST			12b. KIND OF BUSINESS OR INDUSTRY DENTISTRY				
13a. STATE Md.			13b. COUNTY HARFORD	13c. CITY OR TOWN HAURE DE GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2109 FOLEY RD 21078					
14. FATHER'S NAME FIRST VINCENZO MIDDLE VOZZELLA LAST			15. MOTHER'S MAIDEN NAME FIRST ERMINIA MIDDLE LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 029 26 3628			17. INFORMANT MRS. PATRICIA A. VOZZELLA SAME AS #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1599										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)										DUE TO, OR AS A CONSEQUENCE OF (b)			
DUE TO, OR AS A CONSEQUENCE OF (c)										Omental metastasis . 3 months.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-18 1983 to 8-26 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>B. Parekh</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8-25-83				
22d. PHYSICIAN'S NAME [TYPE OR PRINT] B. PAREKH			22e. ADDRESS 1908 Harford Rd. Fallston MD 21047										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 29 AUGUST 83			23c. NAME OF CEMETERY OR CREMATORIAL MT. ERIN CEMETERY			23d. LOCATION CITY OR TOWN HAVRE DE GRACE, HARFORD, MARYLAND			COUNTY STATE	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078			ADDRESS 21078			25a. DATE REG'D. BY REGISTRAR AUG 30 1983			25b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>				

Mr. John T. - Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21935			
1 - FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
<u>WATSON, JAMES E. WATSON</u>					8	5	83				11 ⁰⁵	AM			
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. DATE REC'D. BY REGISTRAR			8. DATE REC'D. BY REGISTRAR			2b. HOUR				
<u>M</u>		<u>W</u>	MONTH <u>4</u> DAY <u>15</u> YEAR <u>02</u>	81							IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>11</u> MIN. <u>05</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<u>Pennsylvania</u>		<u>USA</u>						<u>Harford County</u>			<u>B&O Railroad</u>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<u>Perryman</u>		<u>1825 Park Beach Drive</u>			<u>Engineer</u>			<u>MD 21130</u>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD 21130					
<u>Maryland</u>		<u>Harford</u>		<u>Perryman</u>				<u>1825 Park Beach Dr., Perryman,</u>							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST								
<u>James</u>			<u>Watson</u>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			MD. 21130				
<u>NO</u>		<u>577-07-9603</u>			<u>Jacob Slicer, 1825 Park Beach Dr., Perryman</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carburegast Airst</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Not 1 year</u>			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Carcinoma of lung</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cathex</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Arterial occlusion</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>A.M.</u> DAY <u>15</u> MONTH <u>8</u> DAY <u>19</u> YEAR <u>83</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Arterial occlusion</u>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (the medical examiner) the body after death.															
22b. SIGNATURE <u>MANUEL M. LAZATIN</u>		22c. DEGREE <u>M.D.</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED <u>8/5/83</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAZATIN, MANUEL</u>		22e. ADDRESS <u>P.O. Box 519 Aberdeen, MD 21001</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7 AUG 1983</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Flintstone Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Flintstone Allegheny</u>		COUNTY	STATE <u>MD</u>						
24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</u>		ADDRESS <u></u>			25a. DATE REC'D. BY REGISTRAR <u>AUG 10 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>								

216 188 2 9

1950-51 - 1951-52 - 1952-53 - 1953-54

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number of years from

survivors
beginning in January

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years

DECEMBER

decided to begin at 2001, really now. December

2001

then proceed

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and

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR Item 19a&B file # 583
1 - STATE REGISTRAR 9-8-83 cn

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21936

1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>JAMES</u> <u>WATTERS</u>	MIDDLE <u>Fletcher</u>	LAST <u>WATTERS</u>	2a. DATE OF DEATH MONTH DAY YEAR	MONTH <u>8</u>	DAY <u>17</u>	YEAR <u>83</u>	2b. HOUR HOUR <u>2:44</u> M
3 SEX <u>M</u>	4 RACE <u>B</u>	5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>74</u>	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u>				
10. CITY OR TOWN OF DEATH <u>HARFORD</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HARFORD Memorial Hospital</u>			11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Mechanic</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>Joppa</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ADDRESS <u>2117 Singer Road 21085</u>			
14. FATHER'S NAME FIRST <u>John</u>		MIDDLE <u>Wesley</u>	LAST <u>Watters</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Annie</u>		MIDDLE <u>Elizabeth</u>	LAST <u>Bailey</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>705-09-7555</u>		17. INFORMANT Mrs. Beulah Watters, 2117 Singer Road, Joppa		ADDRESS <u>Md. 21085</u>			
18. CAUSE OF DEATH (Enter only one cause per line for part 1a and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CITF palm. edema</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>(b) ACCORD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <u>Permanent pace maker</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION <u>6-13-80</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Sick sinus syndrome</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) <u>8-16 83</u>		21f. LOCATION STREET <u>8-17 83</u>		CITY OR TOWN <u>8-17 83</u>		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>8-16 83</u> to <u>8-17 83</u> , that (I) (we) last saw the deceased alive on <u>8-17 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Lee MD</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <u>Abingdon Med Clinic 1010 G</u>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Lee</u>		22g. ADDRESS		22h. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b. DATE <u>Aug. 20, 1983</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Zion Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Joppa</u>		COUNTY <u>Harford</u>	STATE <u>Md.</u>
24 FUNERAL DIRECTOR NAME <u>Howard K. McComas III, Abingdon, Md. 21009</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 19 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John G. Comer</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 21937				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1983							2b. HOUR 2:37 P M				
1. DECEASED NAME (TYPE OR PRINT) William GOLDON WORKMAN			5. DATE OF BIRTH MONTH JUNE DAY 15, YEAR 1943			6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
3. SEX MALE			4. RACE white			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) LABORER			12b. KIND OF BUSINESS OR INDUSTRY BUILDING SUPPLY					
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN CHURCHVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3174 ALDINO ROAD 21028					
14. FATHER'S NAME FIRST WILLIAM MIDDLE GREEN LAST WORKMAN			15. MOTHER'S MAIDEN NAME FIRST LUCY MIDDLE LAST WHEATLEY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 232 64 8859			17. INFORMANT RICHARD C. WORKMAN 131 FRANCIS STREET HAVRE de GRACE, MD			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 Cardiac arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blood Dyscrasy														
Due to, or as a consequence of (c) Liver cirrhosis														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Charles J. Foley Jr. M.D.										22c. DATE SIGNED				
22d. PHYSICIAN'S NAME CHARLES J. FOLEY JR. M.D.										22e. ADDRESS HARVE DE GRACE, MD. 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 24 AUGUST 83			23c. NAME OF CEMETERY OR CREMATORIUM WORKMAN CEMETERY			23d. LOCATION CITY OR TOWN BOONE CO., WEST VIRGINIA					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME MITCHELL FUNERAL HOME HAVRE de GRACE, MARYLAND 21078										25a. DATE REC'D. BY REGISTRAR AUG 24 1983				
										25b. REGISTRAR'S SIGNATURE John J. Calvert				

